Department of the Navy
Family Advocacy Program
Service Need and Service Response

Phase III Report:
Summary & Conclusions

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October 1983

DEPARTMENT OF THE NAVY
FAMILY ADVOCACY PROGRAM:
SERVICE NEED AND SERVICE RESPONSE

PHASE III REPORT: CONCLUSIONS

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This report reviews the scope of the Department of the Navy's family advocacy research project and presents an overview of major findings from the study. It also generates testable hypotheses from the data and suggests areas for further empirical investigation.

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FOREWORD

This is the final report on the Department of the Navy's Family Advocacy Program. The research was sponsored by the Office of Naval Research and was conducted by SRA Technologies, Incorporated. The first report, Reconnaissance, was completed in February 1983. It reviewed the scope and nature of abuse and neglect in the military and examined past responses to the problems as reported in available military and civilian literature.

The second report, Assessment, expanded on the initial data and examined the structure and operation of Navy Family Advocacy Programs at the command level. Completed in September 1983, the report was based on site visits to 13 Navy and Marine Corps installations and in-person interviews with a broad spectrum of Department of the Navy and civilian personnel at each selected site. The report served two purposes. First, it described program conditions observed in the field and identified major program strengths, concerns, and dilemmas. Second, it identified program needs and included recommendations from field representatives for program improvement. By describing and assessing current family advocacy program activities at the base level, the report provides a foundation for more effective decisionmaking among Navy and Marine Corps policymakers, program designers, and practitioners who are responsible for family advocacy planning and intervention.

This report, Conclusions, reviews the scope of the project and presents an overview of Phase I and Phase II findings. It also generates testable hypotheses from the data and suggests areas for further empirical investigation. The executive summaries from the Phase I and Phase II reports also are included for a more complete overview of study findings. The report concludes by presenting three resource papers that briefly summarize the available literature on child abuse and spouse abuse, and describe the evolvement of military family advocacy programs. By providing a ready resource for briefings and community presentations, these resource papers should be particularly helpful to Navy and Marine Corps family advocacy practitioners.

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ACKNOWLEDGEMENTS

Grateful appreciation is expressed to the many people who were instrumental in the development and success of this project. Special thanks goes to the Office of Naval Research for its support in this effort. The project reflects the continued leadership and commitment of the Department of the Navy to respond to the serious issues of abuse and neglect.

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DEPARTMENT OF THE NAVY FAMILY ADVOCACY PROGRAM

SERVICE NEED AND SERVICE RESPONSE

PHASE III: CONCLUSIONS

DEPARTMENT OF THE NAVY FAMILY ADVOCACY PROGRAM: SERVICE NEED AND SERVICE RESPONSE PHASE III: CONCLUSIONS

In September 1982, the Department of the Navy through the Office of Naval Research solicited innovative research proposals that would help provide the information necessary to guide the Navy's response to the problems of abuse and neglect. In the bidders' briefing, the Navy contract representatives posed several critical research questions:

- What is the incidence of abuse and neglect within the Navy and Marine Corps?
- Who is most likely to be involved in abuse and neglect and under what circumstances?
- How effectively are Navy and Marine Corps family advocacy policies and programs responding to the issue of abuse and neglect?
- What are the specific characteristics of programs and services that have proven successful in the prevention and treatment of abuse and neglect?
- What is the history and current status of family advocacy policies and programs in the military services?
- What actions can the Navy and Marine Corps take that will increase the effectiveness of its policies and programs aimed at preventing and treating abuse and neglect?

While there were numerous possible research options to address these questions, SRA Technologies, Incorporated selected a comprehensive approach designed to maximize the collection of new information within the limited time and resources available.

Key features of the approach included:

- A completely integrated research plan so that each project activity feeds into other activities and responds directly to one or more of the research questions;

- Multiple data sources and collection techniques to produce a convergence of sociological, anthropological, and statistical evidence; and

- Intensive field research at representative bases to collect quantitative and qualitative data on reported incidents, perpetrators and victims of abuse and neglect, and program characteristics and effectiveness.

The research plan was divided into three phases: Phase I: Reconnaissance; Phase II: Assessment; and Phase III: Conclusions and Recommendations. The overall goal of the research effort was to provide the Department of the Navy with selected and targeted research to guide family advocacy policy and program choices. Working with representatives from the Office of Naval Research, the Naval Medical Command, and the Navy and Marine Corps Family Support Programs, six major research objectives were specified to guide the research effort:

- Project the incidence of abuse and neglect among Navy and Marine Corps personnel and families;

- Construct demographic and social profiles of Navy and Marine Corps personnel and their families involved in abuse and neglect;

- Examine past responses to abuse and neglect as reported in available military and civilian literature;

- Describe the structure and operation of the Department of the Navy's Family Advocacy Program at the command level;

- Assess the current relationship between service need and service response; and

- Enable, through the provision of baseline data, the reinforcement, refinement, and development of family advocacy policies, programs, and activities that contribute to the prevention and remediation of abuse and neglect.

Phase I: Reconnaissance

Phase I of the research reviewed the scope and nature of abuse and neglect and examined past responses to the problems by summarizing the military and civilian literature. The Phase I report, Department of the Navy Family Advocacy Program: Reconnaissance, was designed as a comprehensive sourcebook to Navy and Marine Corps policymakers, program designers, and practitioners who are responsible for family advocacy planning and intervention and whose decisions depend upon the best available information.

The report consisted of five chapters. The first three chapters of the report reviewed the problems of child maltreatment, spouse abuse, and sexual assault and rape, respectively. Each of these chapters had six major subdivisions:

- Background
- Incidence
- Consequences
- Associated Factors
- Explanations
- Prevention and Intervention.

The aim was to provide an overview of the current state of knowledge on each of these problems. Although these chapters relied heavily on civilian literature, military literature was reviewed where available, and

extrapolations were drawn from the civilian to the military population. Special attention was directed to the Navy and Marine Corps populations.

Chapter IV traced the history of family advocacy in the military. The chapter included a review of the DoD Directive establishing an all-service Family Advocacy Program, as well as the current status of the military services in response to the Directive.

The Navy Family Advocacy Program was reviewed in Chapter V. An overview was provided of its scope, organization, and operation. This chapter also described the Navy Family Support Program, the Marine Corps Family Service Program, and their roles in the Navy Family Advocacy Program. The report concluded with an overview of Phase I results and presented implications of the report for policymakers and practitioners in the area of family advocacy. Also, strengths and weaknesses of available research were identified and preliminary hypotheses were presented for the remaining phases of the project.

Together these chapters provided an important theoretical and empirical overview of abuse and neglect in the military today and past responses to these problems. They represent another step for the Navy and Marine Corps in responding more effectively to the problems of abuse, neglect, sexual assault, and rape.

Although the military services have actively responded to the problems of child maltreatment, spouse abuse, and sexual assault, and rape in military communities, results from the reconnaissance phase of the research concluded that military policies, programs, and intervention techniques often have been hampered by insufficient and unreliable data. Concerning the prevalence and nature of abuse and neglect in the Navy and Marine Corps and the Department of the Navy's response to these problems, findings indicated:

- Little data exists on the incidence, prevalence, nature, or distribution of child and spouse abuse and neglect, sexual assault and rape in either the Navy, Marine Corps, or other military

services and data exists in limited scope and quantity for civilian populations. Because of this, it was concluded that the calculation of military prevalence rates and the construction of "at-risk" profiles are premature at this point.

- Military studies on need conditions and program responses are difficult to obtain, shallow in depth, limited in number, and contradictory in findings.

- The Department of the Navy has adopted adequate definitions of child and spouse abuse and neglect, sexual assault and rape to begin and support need identification and service responses.

Concerning the condition of military responses to needs of military personnel and families, the findings indicated that:

- A variety of educational conferences and workshops have been conducted in recent years to educate professionals to the sensitive issues of abuse and neglect, but there has been limited professional training to assist military policy and program designers, budget officers, service practitioners, and associated civilian personnel.

- Detailed policy statements have been issued by the Department of Defense and the individual services providing program goals and general philosophies. However, there has been no issuance of specific objectives to be achieved within specified time periods and there has been limited funding to support new or expanded service operations.

- Except for a partial evaluation of the Child Advocacy Program which began several years before the Family Advocacy Program, there has been no program assessment to indicate the success of the military's response to abuse and neglect to date, and there has been little effort to seek out and learn from civilian program models.

In summary, information about the nature and extent of abuse and neglect in the military is indeterminate and must continue to rely heavily on extrapolations from civilian data. By providing a comprehensive review of the existing civilian and military literature on abuse and neglect and responses to these problems, the Phase I reconnaissance report provides the foundation to identify and test the following research hypotheses:

- The incidence of abuse and neglect is at least as common in the military community as it is in the civilian population.

- Factors associated with abuse and neglect in civilian communities will not necessarily have direct application for military communities.

- Various factors interact in complex ways to create a situation promoting or contributing to abuse and neglect; the occurrence of any abuse or neglect incident cannot be explained by a single factor or indicator.

- Explanations for abuse and neglect behavior will be found in factor combinations of past learning, personal and social stresses, and inadequate community linkages and supports.

- There is a traceable cycle of abuse and neglect in family generations which can be identified, treated, and prevented.

- Preliminary profiles of potential abusers and neglecters in military communities can be developed from combining Phase I data with information from the Central Registry Files of established cases of abuse and neglect.

- The success of intervention programs and techniques will be based on the degree that social-medical-legal-judicial service linkages are established and work together in cooperative and coordinated relationships.

- Given the history of the family advocacy movement in the military and the availability of civilian resources to augment military resources, the program responses to child maltreatment at Navy and Marine Corps bases should be more fully developed than those for spouse and sexual abuse.

- Critical follow-up of victims and offenders occurs in direct proportion to the confidentiality of data and privacy of service settings provided to them.

- The level of program support at each base is in direct proportion to the policy goals and staff resources visibly provided by the local base and hospital commanding officers.

- Benefits to the military and individual families from treatment and prevention program investments can be translated into cost savings information for the Department of Defense and the Department of the Navy.

- Existing civilian and military intervention and prevention models can become training modules for Navy and Marine Corps leaders and professional practitioners.

Phase II: Assessment

Phase II of the research expanded on the initial baseline data from Phase I and examined the structure and operation of Navy Family Advocacy Programs at the command level. The report was based on site visits to 13 Navy and Marine Corps installations and in-person interviews with a broad spectrum

of Department of the Navy and civilian personnel at each selected site. The report served two purposes. First, it described program conditions observed in the field and identified major program strengths, concerns, and dilemmas. Second, it identified program needs and included recommendations from field representatives for program improvement. By providing descriptive information about current family advocacy program activities at the base level, the report should lead to more effective decisionmaking among Navy and Marine Corps policymakers, program designers, and practitioners who are responsible for family advocacy planning and intervention.

The Phase II report, Department of the Navy Service Need and Service Response: Assessment, was divided into three sections. Section I presented brief descriptions and analyses of the Family Advocacy Programs at each of the 13 sites visited during the course of the study. The aim of this section was to provide an overview of the context, structure, and operation of base responses to abuse and neglect. Recommendations from base personnel for improving service response to family advocacy issues were reported for each site. Section I provided an important foundation for the integrated analysis of base programs in Section II.

Section II synthesized data and provided a comparative analysis of program responses to abuse and neglect. Using BUMEDINST 6320.57 as a reference point, the aim was to analyze the structure and operation of the Family Advocacy Program across sites and discuss program recommendations from the field particularly as they relate to reducing the gaps between family advocacy service needs and service responses.

The report concluded with an overview of Phase II results and outlined current Family Advocacy Program strengths, concerns, dilemmas, and keys to success. Implications of the report for family advocacy policymakers and practitioners and a discussion of data strengths and limitations completed the report.

Together, these sections provided a foundation for understanding the current status of the Department of the Navy Family Advocacy Program in the field. Such information is important for refining the existing program and developing new service models and initiatives.

Results from the assessment phase of the research documented wide variations in Family Advocacy Program structure and operation across installations. Regardless of their program status, however, most base personnel recognized the seriousness of abuse and neglect and the importance of responding to these problems through effective interagency cooperation and coordination. Differences in base and community resources and the perceived scope of abuse and neglect often were intervening variables in program development. In general, the more base personnel perceived abuse and neglect as community problems and the greater the availability of military and civilian helping resources, the more effective the response system to abuse and neglect prevention and treatment.

The Phase II assessment report concluded that the Family Advocacy Program currently is confronted by problems that are best described as developmental. For example, the increasing number of abuse and neglect cases identified in Navy and Marine Corps communities have not necessarily been paralleled by increases in program staff and resources. As a consequence, case assessment and disposition is hindered at some bases by an increasing backlog of cases. There also are program delays associated with inexperienced staff and the need for greater program clarity. Such concerns are not intrinsic program flaws, but are obstacles to further program development and refinement.

Other issues facing the Family Advocacy Program are not necessarily program concerns, but dilemmas that require choices between potentially equally justifiable alternatives. In some instances, program dilemmas arise from policies and procedures beyond the control of Family Advocacy Program staff, such as jurisdictional issues stemming from the Status of Forces

Agreement. In other cases, they involve making program and case decisions within policy, resources, and legal parameters.

In summary, results from the Phase II assessment suggested that the Family Advocacy Program is in a state of transition. Although bases are attempting to refine their policies and procedures and improve service delivery and coordination, program efforts are hampered by lack of program clarity, program staff, and community resources for assessment and intervention.

Although the Phase II assessment report provides an important foundation for understanding the current status of the Department of the Navy Family Advocacy Program in the field, care should be exercised in generalizing study findings to bases other than those sampled because of their restricted number and nonrandom selection. Still, it is possible to identify several research hypotheses based on the study findings that can provide a focus for further research:

- The greater the number of base and community helping resources and the greater the interface between services and programs, the more effective the community's response to abuse and neglect treatment and prevention.

- The success of intervention programs and techniques will be based on the degree that social-medical-legal-judicial service linkages are established and work together in cooperative and coordinated relationships.

- In CONUS, the less available and developed the base helping services and programs, the more likely abuse and neglect cases will be referred to civilian agencies for assistance.

- The involvement of line-based personnel in family advocacy will lead to great specification and refinement in program structure and operation.

- The program responses to child maltreatment at Navy and Marine Corps bases will be more fully developed than those for spouse abuse and sexual assault.

- Intake and assessment processes around abuse and neglect cases are most effective when cases originate within the hospital setting; the problem involves child maltreatment; and when the Family Advocacy Representative has adequate time or staff resources to devote to the process.

- Overseas Navy and Marine Corps bases are most likely to have insufficient community and staff resources for responding to abuse and neglect issues.

- Interorganizational cooperation in family advocacy cases is built largely upon good liaison and communication between base and community service organizations and a clear understanding of Family Advocacy Program tasks and objectives.

- Child maltreatment and sexual assault and rape cases are more likely to be self-referred or reported through Family Advocacy Program channels than those dealing with spouse abuse.

- Follow-up and tracking of family advocacy cases are hindered by unclear procedures, shortages of staff resources, and inadequate criteria for changing the status of a case from active to inactive.

- Recent increases in the number of family advocacy cases in the Navy and Marine Corps reflect more improvements in case identification and record keeping than an actual increase in the number of cases.

- Better prescreening of families before overseas assignment for stress-related problems, weak coping skills, and prior Family Advocacy Program involvement will decrease both the number of abuse

and neglect cases overseas and the need for early returns of members and their families.

- The increasing number of abuse and neglect cases without parallel increases in family advocacy program staff and resources will lead to less effective service response and greater reliance on administrative discharge.

- Without clearer policy instruction, staff resources, and skill development among Navy and Marine Corps family advocacy professionals, base programs will continue to focus more on responding to existing abuse and neglect cases than on preventing new ones.

- The Family Service Centers in the Navy and Marine Corps will enhance the delivery and coordination of treatment and prevention services in cases of abuse and neglect.

Implications

During the past year, SRA Technologies, Incorporated has attempted to provide the Department of the Navy with the data necessary to: (1) determine the scope and dynamics of abuse and neglect in the Navy and the Marine Corps; and (2) assess the nature and effectiveness of policies and programs designed to respond to these issues. Although data limitations prevent both the calculation of precise incidence and prevalence rates and the construction of profiles of perpetrators or victims of abuse and neglect, results do suggest the potential extent and seriousness of these issues in the Navy and Marine Corps.

The Department of the Navy has been a leader in developing policies and programs to respond to abuse and neglect. Although results from the investigation document wide variations in program development among bases, program efforts to better respond to abuse and neglect issues were

intensifying at most of the sample bases visited by the SRA project staff during the Phase II assessment. At present, there appears to be a solid foundation in the line and medical communities for family advocacy policy and program development.

Although the current research effort has provided a baseline of information about the extent of our knowledge about abuse and neglect in the military and policy and program responses, it has succeeded more in identifying than filling research gaps. This conclusion should not be interpreted negatively, however. It has lead to the formulation of a number of testable hypotheses that should provide a baseline for policy and program decisions and a catalyst for more informed and targeted research.

Military researchers need to continue to attempt to refine profiles of victims and perpetrators of abuse and neglect. Only then can an operational model of protection, prevention, and intervention be developed that allows individuals and families vulnerable to abuse and neglect to be targeted for treatment and prevention services. Efforts to refine estimates of abuse and neglect in the Navy and Marine Corps communities also must continue. These figures are not only important in determining the extent of the problem, but also provide the means for justifying the allocation of scarce resources and serve as a baseline for evaluating prevention and treatment efforts.

The Department of the Navy also should continue to refine its response to abuse and neglect through carefully conducted program evaluations. Such research serves as a vehicle for refining policies and practices; identifying models for others to follow; and determining program impacts. Information from program assessment is a key to program success and accountability. Further research, for instance, is needed to determine the interactions, if any, between mission and command dynamics, incidence of abuse and neglect, and variations in program response. Such data becomes a vehicle to refine treatment and prevention efforts.

The seriousness of abuse and neglect in the Navy and Marine Corps and its potential implication for mission readiness demands continued attention. Researchers must continue to explore the complexities of this problem. Only then can programs and services be built on facts rather than assumptions, real needs rather than assumed needs.

APPENDIX A

PHASE I: RECONNAISSANCE

EXECUTIVE SUMMARY

PHASE I: RECONNAISSANCE

EXECUTIVE SUMMARY

Freedom from fear of personal harm among family members is a right all citizens should enjoy. However, reports of increasing sexual assault, spouse abuse, and child maltreatment among civilian and military families violate this principle. The credibility of these reports and their significance to the Navy and Marine Corps, particularly the Navy Family Advocacy Program, are the subjects of this report.

The Research

The Department of the Navy through the Office of Naval Research requested an indepth review of the extent and nature of personal abuse and neglect in the Navy and Marine Corps, and an assessment of how the Navy Family Advocacy Program, designed to address these problems, is performing worldwide. SRA Corporation of Arlington, Virginia was contracted in 1982:

- To learn the numerical extent and nature of abuse and neglect incidence, conditions, and effects in the military;
- To develop baseline data and profiles of at-risk military families, based on literature research and site visit case studies at 13 Navy and Marine bases in five states, Japan, Italy, and Sardinia;
- To compare military and civilian populations for incidence, prevalence, and at-risk profiles;
- To access the operation of the Navy's Family Advocacy Program at the command level; and
- To develop recommendations for future military policies, programs, and budget planning.

The project will be completed in the fall of 1983 with two more reports. This report compiles the most up-to-date information on family advocacy provisions in all the military services; examines the evolution of military family advocacy programs; describes the Family Advocacy Program in the Department of the Navy; and provides a detailed summary of the available literature on incidence, conditions and effects of abuse and neglect in the military.

Literature sought for this comprehensive review focused on military and civilian studies of and responses to personal abuse and neglect issues.This included sources on sample case incidence reports and public intervention policies and service programs. Also investigated were definitions of abuse and neglect categories; theories of causation, prevention, and treatment; legislated definitions, reporting mechanisms, judicial intervention, and treatment guidelines; and evaluations of staff training and treatment programs. Special attention was given to military policy and procedural directives and program operations, especially those in the Navy and Marine Corps. All references to studies and other sources of information have been thoroughly cited in each chapter of the report.

Incidence

What has been learned from the literature is that very little has been documented on the scope of personal abuse and neglect in civilian or military populations. Because of limitations in military literature, data from the civilian population became the primary information source. Findings from the military are provided where available, and extrapolations are attempted from the civilian to the military population.

Despite the tendency toward underreporting of abuse and neglect incidents, the transformation of personal abuse and neglect from a private issue to a public concern began in the 1960s. Following a 1970 survey of officially reported child abuse cases, Congress passed the Child Abuse Prevention and Treatment Act of 1974 and established the National Center on

Child Abuse and Neglect. By 1973, all 50 states had enacted state mandatory reporting laws concerning child abuse and neglect.

Child Maltreatment. Child maltreatment became the focus of early research studies, demonstration projects, conferences, and legislative initiatives. Service programs have since been implemented in civilian and military communities to protect children and to work with abusers. Despite this widespread interest and concern, the real incidence of child maltreatment remains unknown.

The magnitude of child abuse and neglect in the nation has been difficult to measure because many incidents still go unreported. Estimates of child abuse and neglect in the military have been based on limited data from general studies and often have been compared with civilian estimates.

Early estimates of incidence in the military ranged from a problem that is minimal, similar to civilian populations, abundant, to four times greater than civilian populations. While these early studies were of questionable validity, base-level medical personnel in all the military services were prompted to establish formal child abuse programs in the 1970s.

Research on the problems of child maltreatment among military families is scattered and unsystematic. Information primarily is clinically descriptive and based on small, unrepresentative samples of reported cases in the military. Reporting problems have been uncovered and they include unreported cases due to complicated paperwork, and cases being reported at medical or other service treatment centers and not entered into official reporting systems.

From studies conducted during the 1970s, annual child abuse incidence ranged from 30,000 to 1.5 million for the total population with 1,500 to 2,000 in the military population. The National Center on Child Abuse and Neglect has estimated 1 million incidents occur annually, resulting in 2,000 deaths. Based on recent civilian reporting techniques and

extrapolating from the 652,000 reported cases in 1980 for the total population, incidence for the military approximates 15,500.

Other indicators show that children younger than six have the highest risk of physical abuse and comprise 80 percent of all physically abused children, whereas older children are more frequently the subjects of sexual abuse and neglect. Although neglect is the most common type of child maltreatment, research has focused on physical abuse. Interest in researching sexual abuse has been comparatively recent. Investigators continue to struggle with developing precise and acceptable definitions of child maltreatment.

Spouse Abuse. There also are important gaps in the research on spouse abuse and neglect. No specific data exists on incidence in the military and estimates from civilian samples are crude projections. Although there are mandatory reporting requirements for child abuse and neglect in all the states, there are no regulations for reporting spouse abuse and marital rape as detected by physicians and other service professionals.

Reliable data is lacking for the general population as well, although one 1980 study estimated that one in every 22 women are abused by their husbands. Earlier estimates put the total number as high as 28 million. There is little empirical data available to compare civilian with military rates because the civilian studies offer no simple cause and effect explanation.

The Navy added a spouse abuse component to the existing Child Advocacy Program in the late 1970s. This was a logical addition because both phenomena are forms of domestic violence and may occur in the same family. But response to these problems remain separate because prevention and treatment strategies for child and spouse abuse are quite different.

There are state mandated and funded mechanisms, such as protective services, that can back up Navy resources for child abuse; analogous services for battered adults do not exist. No existing data can be found

to evaluate the true effectiveness of intervention methods, including those being used in the Navy and Marine Corps.

Rape. Practically all the research on rape has been done in the past ten years. It has uncovered demographic, attitudinal, and psychological aspects, but not direct causes. Rape is not a well understood phenomenon and has received very little study in the military. Aspects that might contribute to the occurrence of rape or inhibit sexual assault have not been well researched.

The research generally has come from studying victims in rape crisis centers or police files and convicted offenders. In both cases, these groups probably are not representative of the larger group of victims and rapists because many victims choose not to report the assault to family, friends, police, or medical professionals for fear of reprisal, stigmatization, or trauma in giving detailed testimony.

Over half the victims of rape are age 20 years or younger and unmarried, although 15 percent of reported cases involve women over 30 years. Minority women are more likely to be sexually assaulted: black and hispanic women are overrepresented in relation to their total populations. Most convicted offenders average four to five years older than their victims. Racial minorities also are overrepresented in the offender population.

Most of the attention to rape and sexual assault has come from citizen activist groups and women's organizations to focus public awareness on the victimization experience and the inadequately responding criminal justice and human service systems. The military community has begun to review rape and sexual problems and responses. Gains in the civilian study sector can help improve military programs for victims, families, and offenders. Some suggestions for integrating successful program models have been presented in Chapter III of this report.

Gaps in the research occur in identifying characteristics of offenders, psychological and emotional effects to the victim and the community, and appropriate treatment methods. For issues that have been studied, the applicability to Navy and Marine communities can only be inferred.

Causation

A number of studies have examined demographic, individual, relational, and situational factors as cause indicators of personal abuse and neglect. These have included age, sex, race, religion, education, occupation, urban/rural background, intelligence, self-esteem, mental health, marital status, parental influence, stress, social membership and communication

It is likely that various factors interact in complex ways and reinforce each other to create a situation conducive to forms of personal abuse and neglect, but efforts to understand this interplay are just beginning. Developing these factors into an operational model of detection, prevention, and intervention is still the challenge.

However, instances of family violence are found to be more common among younger families with limited income and men with high school education. More than half the military personnel are younger than 30, as compared with 25 percent of the civilian population, and the majority are married with small children. These factors alone tend to make the military a high risk group for family violence and personal abuse.

Given the defensive nature of the military mission and the rigid chain of command, military personnel may be more prone to violent and aggressive behavior than the civilian population. This speculation has some empirical support but the findings are not conclusive. Further investigation is needed to understand fully the nature and extent of violent and aggressive behavior in the military and how its magnitude and characteristics differ from civilian populations.

Military Responsiveness

As published reports emerged between 1960 and 1970, calling for responsive countermeasures to child abuse, similar appeals appeared in military communities. A decade later, local initiatives also were directed toward spouse abuse, and the military developed a similar response.

By 1975, all 14 Naval Regional Medical Centers had developed child maltreatment policies and procedures, along with 19 of the 21 smaller Navy hospitals. By 1976, each of the military services had issued a regulation establishing a formal child advocacy program.

When concern over further domestic violence intensified in the mid-1970s, Child Advocacy Programs at Navy installations were expanded to prevent and treat spouse abuse. In July 1979, the Bureau of Medicine and Surgery issued BUMED Instruction 6320.57, creating the Navy Family Advocacy Program.

This program provided policies for handling child maltreatment, spouse abuse, sexual assault, and rape among Navy and Marine Corps personnel and families. Program guidance was offered in areas of case identification, assessment, followup, prevention, and interagency cooperation.

In 1979, the Navy Family Support Program also was established and the Marine Corps added a Family Service Program a year later. These two programs created additional resources in the form of Family Service Centers. Currently, there are 22 funded Family Service Centers in the Navy, with 40 more planned by fiscal year 1984. The Marine Corps has 17 operational centers.

At this time, the Navy Family Advocacy Program is being reorganized so that Navy and Marine Corps Family Centers will assume more identity and responsibility for operations. The Navy medical community will continue to play a critical role in responding to victims and abusers.

All four military services expanded their family advocacy efforts and began to coordinate activities in 1981 after the Department of Defense issued an all-service policy directive mandating official establishment of a Family Advocacy Program. Policies for prevention, evaluation, and treatment of child abuse and neglect and spouse abuse are being issued and modified, and training is being developed for personnel working closely with family advocacy issues.

Organizational and policy developments alone will not solve the complex problems of personal abuse and neglect. A shortage of funds could jeopardize plans for improving the program responses in each military service. The significance of firmly establishing these plans lies in the recognition of the problems of abuse and neglect and the changing composition of military manpower.

The Military Community

The military careerist with a family increasingly makes up the roster of all the Armed Forces. Attendant with this change are the opportunities and problems surrounding marital status. Contemporary trends in marriage, divorce, single parenthood, and dual careers are reflected in all American families. But military families experiencing new definitions of parental and spouse responsibilities also must handle the stresses unique to the military way of life--the periodic cycles of separation and reunion; major changes in residence every two to three years; social isolation from family and friends in remote locations; constant readiness for military missions; high concentrations of foreign-born wife marriages; and prevalence of alcohol and drug abuse.

Conditions of peacetime, changing economies, and other factors have attracted more families to the military. The Armed Forces no longer represent a single, male group: members with families comprise over 55 percent of the total force. The change in military personnel has brought the benefits of a more stable defense manpower base and a continuing source

of personnel. Children reared in military families are more than twice as likely to build their own military careers.

The linkages between military retention and performance and family and personal well-being are well established in the research. Conditions surrounding personal security decidedly strengthen this linkage. The traumatic personal violation of child abuse or rape has been found to have longstanding effects--on the victim, the abuser, and the community. The learned helplessness of sexually assaulted persons certainly undermines a core principle of military defense readiness.

There is evidence that abusers previously were victims and, left untreated, will become involved in further acts of violence and enter the judicial system. It is this cycle of self-destructive behavior that must be broken. If it is not, the consequences will be overburdened medical, legal, judicial, social and personnel systems. The impairment to the military member, whether victim or abuser, can mean further physical and psychological damage and continued abnormal family functioning. For the Navy and Marine Corps, these results will be translated into lower morale, distorted judgment, weaker performance, reduced defense readiness, and a turnover in manpower.

The underlying dynamics of personal abuse and neglect still are insufficiently understood. There is little statistical proof of the severity of these problems in either civilian or military communities. Without this data base, it remains difficult to know whether present family support services are as effective as they could or should be since data does not exist for performing adequate evaluations.

The development of research and more responsive services have been hampered by narrow perceptions of the problems, uncoordinated data collection procedures, inadequate funding, and fragmented service delivery. Program planning and budget allocations are being made without benefit of this basic information. The second and third phases of this study will help narrow this information gap and with additional

information, the forward-thinking human resource professionals in the Navy and Marine Corps can choose ways that decidedly strengthen the supportive military family and healthy, productive personnel.

APPENDIX B

PHASE II: ASSESSMENT

EXECUTIVE SUMMARY

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EXECUTIVE SUMMARY

Family Advocacy Programs exist in all branches of the Armed Services. In the 1970's the Chief of the Bureau of Medicine and Surgery (BUMED) established an Instruction for the Department of the Navy Medical Corps. In 1981 the Department of Defense issued a Family Advocacy Directive which mandated line involvement in the program. At present, the Office of the Secretary of the Navy is drafting an Instruction which will delineate the responsibilities toward family advocacy shared by the Navy Medical Command, the Marine Corps, and the U.S. Navy.

The Instruction referred to throughout this report is the one issued by the Bureau of Medicine and Survey.

Commanding officers of all Naval medical facilities are responsible for implementing local Family Advocacy Programs at their facilities. Naval regional medical centers and hospitals must establish local policies and directives for implementing a Family Advocacy Program at their commands. A Family Advocacy Representative and a standing Family Advocacy Committee are established at the medical facility that oversee the operation of the local program, make plans for the management of cases, and submit recommendations on program management to the commanding officer of the hospital.

This investigation examines the structure and operation of the Family Advocacy Program at the command level. Study objectives, design, findings, and conclusions are summarized in the following sections. The format of the summary is generally consistent with the report format which includes three major sections: (1) Family Advocacy Program Descriptions; (2) Program Overview; and (3) Conclusions.

THE RESEARCH

The Department of the Navy through the Office of Naval Research requested an indepth review of the extent and nature of personal abuse and neglect in the Navy and Marine Corps, and an assessment of how the Navy Family Advocacy Program, designed to address these problems, is performing worldwide.

SRA Technologies of Arlington, Virginia was contracted in 1982:

- To learn the numerical extent and nature of abuse and neglect incidence, conditions, and effects in the military;
- To develop baseline data and profiles of at-risk military families based on literature research and site visit case studies at 13 Navy and Marine Corps bases in five states, Japan, Italy, and Sardinia;
- To compare military and civilian populations for incidence, prevalence, and at-risk profiles;
- To assess the structure and operation of the Navy's Family Advocacy Programs at the command level; and
- To develop recommendations for future military policies, programs, and budget planning.

The project will be completed in the Fall of 1983.

This report, the second of three planned, presents an assessment of the effectiveness of the Navy Family Advocacy Program at the command level. Based on site visits to 13 Navy and Marine Corps bases worldwide, the assessment was guided by the following objectives:

- Describe the structure and operation of the Navy's Family Advocacy Program at the command level;

- Assess the current relationship between service need and service response;

- Identify major program strengths, concerns, and dilemmas;

- Document effective program practices;

- Examine the extent of liaison between medical personnel and nonmedical personnel in the treatment and prevention of abuse and neglect; and

- Identify program needs and recommendations for program improvement.

The report is intended to provide an in-depth review for Navy and Marine Corps policymakers, program designers, and practitioners who are responsible for family advocacy planning and intervention and whose decisions depend upon the best available information.

Using a case study approach, the assessment was conducted at 13 Navy and Marine Corps bases: Naval Station, Charleston; Marine Corps Air Station, Cherry Point; Naval Air Station, Brunswick; Naval Air Station, Memphis; San Diego Area Activities; Marine Corps Base, Camp Pendleton; Marine Corps Air Ground Combat Center, Twentynine Palms; Marine Corps Logistics Base, Barstow; Fleet Activities, Yokosuka; Marine Corps Air Station, Iwakuni; Naval Air Facility, Atsugi; Naval Support Activities, Naples; and Naval Support Office LaMaddalena. Approximately 300 in-person interviews both individual and group, were conducted with a broad sample of Department of Navy and civilian personnel across the 13 bases: command leadership, medical personnel, Navy and Marine Corps human service providers, security and legal personnel, base volunteer groups, and representatives from civilian agencies.

In addition to interviews, SRA project staff attended family advocacy committee meetings, examined case records, and visited base and civilian support facilities. SRA designed interviewing and recording guides to

structure interviews and observations, and to provide data consistency among project staff.

After collecting and aggregating the data from the interviews, case records, and observations, SRA staff prepared summary case study reports for each site visited. SRA then compared data across commands on the key variables of the study. This analysis focused largely on differences in the structure and operation of the individual programs and the reasons for these differences.

Although the bases chosen for the assessment were selected because of variations in command responsibilities, geographic location, base demographics, and availability and sophistication of support services, care is recommended in generalizing study results to other Navy and Marine Corps installations because of the restricted number of sites and their non-random selection. Still, study results do make a heuristic contribution to understanding the current status of the Department of the Navy Family Advocacy Program and provide a foundation for developing hypotheses at other Navy and Marine Corps installations.

FAMILY ADVOCACY PROGRAM DESCRIPTIONS

This section provides summary descriptions of the 13 Family Advocacy Programs visited during the course of the assessment. Its purpose is to provide a general overview of responses to abuse and neglect across Navy and Marine Corps installations. In highlighting program variations across sites, the section provides an important foundation for discussing the overall structure and operation of the Family Advocacy Program.

Each program profile contains information organized in the following categories:

- **Introduction:** geographic location and mission of the base or installation, population demographics, stress factors for families, and available support services.

- **Program Context:** the nature of the medical facility, staffing patterns, and history and development of the Family Advocacy Program.

- **Program Structure:** the number and composition of the Family Advocacy Committees, frequency of Family Advocacy Committee meetings, and role of the Family Advocacy Representative.

- **Program Operation:** the number of abuse and neglect cases, the nature of interorganizational cooperation, types of referral sources, and recommendations of respondents for program improvements.

- **Current Directions:** new or planned Family Advocacy Program developments, obstacles to effective response, and recommendations of respondents.

Findings from the program descriptions document wide variation in program structure and operation across installations. Some base programs are more developed and integrated than others. Regardless of their program status, however, most base personnel recognize the seriousness of abuse and neglect and the importance of responding to these problems through effective interagency cooperation and coordination. Differences in base and community resources and the perceived scope of abuse and neglect often are intervening variables in program development.

PROGRAM OVERVIEW

The 13 Family Advocacy Programs assessed during the site visits exhibit both similarities and differences in program structure and operations. Although some Family Advocacy Programs closely follow the program guidelines set forth in BUMED Instruction 6320.57, those at other sites are more rudimentary. Differences between programs more often result

from variations in available resources and program history than from lack of concern and initiative for program development.

This section of the report discusses distinctive program variations, provides explanations for these differences, and presents program issues raised by respondents and observed by research teams during the site visits. The issues chosen for discussion reflect general program concern and are not specific to any particular location. The section concludes by outlining recommendations from base respondents for increasing program effectiveness.

Program Context

Sites chosen for the study represent the heterogenous character of Navy and Marine Corps locations and functions. The aim was to assess the development, structure, and operation of the Family Advocacy Program across a number of demographic, mission, and support service variables. The range of site contexts alone provided several straightforward explanations for Family Advocacy Program variations:

- Smaller bases and hospital facilities usually have one rather than three working subcommittees; otherwise the same personnel would be assigned to all three.

- Overseas installations are dependent on base resources for family advocacy case investigation and intervention because civilian resources are unavailable.

- At small CONUS bases, family cases requiring treatment services often are referred to civilian resources because of the shortage of hospital and base facilities and personnel.

- Unlike CONUS installations, overseas Family Advocacy Committee discussions often focus on the merits of the "early return" of families involved in abuse and neglect.

- Bases with a entry-level technical training mission have less well developed Family Advocacy Programs because of the transient nature of the population.

- Navy Family Advocacy Representatives are more likely than civilian Family Advocacy Representatives to have additional collateral duty responsibilities.

All the Family Advocacy Programs examined share one element in common: the evolution of greater specification and refinement in program structure and operation. The development of line-based activities in family advocacy areas is a major reason for program change. Stimulated by the forthcoming SECNAV Instruction, training sessions in family advocacy issues, and the recently issued Marine Corps Family Advocacy Order, the awareness of advocacy issues is spreading throughout the Navy and Marine Corps communities.

Another influence on the Family Advocacy Program, especially at smaller installations, is the introduction of military and civilian social workers into Navy medical settings. Trained hospital social workers expedite the work of the Family Advocacy Committees by assuming investigative and coordinating responsibilities in abuse and neglect cases.

Program Structure

The BUMED Instruction creating the Family Advocacy Program is a policy rather than a program statement intended to set general guidelines for often highly disparate local situations. It outlines a program structure but is less specific about how this structure should operate. The Instruction specifies the number and composition of Family Advocacy Committees, meeting frequency, position and role of the Family Advocacy Representatives and the Duty Family Advocacy Representatives, and procedures for case

reporting. It also directs hospital personnel to perform a number of family advocacy functions: case identification, assessment, treatment, prevention, education, and reporting.

The Instruction stresses the importance of cooperation between base agencies and base and civilian resources, but does not provide detailed guidance about developing and maintaining this cooperation. Given the importance of community response to family advocacy and the need for effective interface between hospital, civilian, and line personnel, this poses a serious problem, especially for inexperienced FAP staff who feel a need for specific procedures.

In general, the BUMED Instruction does not contain detailed program goals nor parameters for program evaluation. Instead, the emphasis is on statistical reporting requirements of family advocacy cases. In addition, the case procedures outlined by the Instruction for handling abuse and neglect cases are more applicable to cases of child maltreatment than to spouse abuse, sexual assault or rape. Frequently, the Instruction combines the problems of child maltreatment and abuse between adults.

The Instruction's emphasis on child maltreatment is reflected in many local programs. Child maltreatment subcommittees usually meet more frequently and regularly than do the other subcommittees. There are no spouse abuse or sexual assault/rape subcommittees at some bases visited. The focus of the Instruction and local programs on child maltreatment stems from both historical factors and the perceived seriousness of the offense, although the recorded incidence of spouse abuse is higher in many locations.

Role of the Family Advocacy Representative. The Family Advocacy Representative plays a key role in the program. On the bases the research team visited, the proportion of time that Family Advocacy Representatives spend in family advocacy related duties ranges from 10 to 100 percent. Most Family Advocacy Representatives, however, have responsibility not only for the Family Advocacy Program, but also for such duties as outpatient and

discharge planning, adoption coordination, weight control programs, social work administration, and medical caseloads.

Results indicate little consensus among Family Advocacy Representatives about their primary duties. Most see their roles as primarily administrative with responsibilities in the areas of case reporting, case management, and program coordination. A few focus as well on clinical practice and perform direct crisis intervention, family mediation, and case investigation. All Family Advocacy Representatives interviewed say that education and prevention of abuse and neglect cannot be given a high priority because of time and resource constraints.

The site visits demonstrated that the Family Advocacy Representative is central to the functioning of the Family Advocacy Program: a good one can turn "a paper program" into an actual one. On the other hand, the simple designation of a Family Advocacy Representative without the ingredients of time, treatment resources, command support, and interest in abuse and neglect problems is insufficient for success.

Role of Committees. The BUMED Instruction mandates a minimum of four types of local family advocacy committees for medical centers, regional medical centers, and hospitals. These include a standing Family Advocacy Committee and three working subcommittees: (1) child abuse and neglect, (2) spouse abuse and neglect, and (3) sexual assault and rape. SRA staff observed Family Advocacy Committee meetings of both central and working subcommittees at five site locations. These observations and the interview data revealed a high degree of variation among bases in the structure, composition, and functions of committees.

In general, however, medical facilities are more likely to have an organized child abuse subcommittee. The presence of spouse abuse/neglect and sexual assault/rape subcommittees is less predictable, even at the larger medical complexes. Program staff often cited too few cases and lack of program staff as reasons for having fewer than the required number of subcommittees.

Committee membership also varies across sites, particularly that of nonmedical personnel. At one end of the continuum, all committee members are medical personnel or assigned to the hospital. Other Family Advocacy Committees, especially subcommittees, are more open to nonmedical personnel, including directors and staff members of Navy and Marine Corps Family Service Centers and command representatives. In CONUS, some but not all child abuse subcommittees invite a representative from the local Child Protection Service unit in the civilian community to attend Family Advocacy Committee meetings.

There is general agreement among Family Advocacy Committee members interviewed that family advocacy subcommittees have three principal tasks. First, they provide case disposition of abuse and neglect cases occurring in their community. Second, they ensure that cases are referred to appropriate service resources. Third, they evaluate the treatment received in the medical setting. Committee members often see the Family Advocacy Representative as the primary response person in cases of abuse and neglect; the subcommittee oversees the Family Advocacy Representative's response and monitors case management.

In general, the focus of the subcommittees is geared more toward case diagnosis than treatment response. At times, diagnostic debates among committee members become time consuming and focus more on personal debates over definitions of abuse and neglect than on responding to an identified need.

In the fall of 1982, a new set of Family Advocacy Coordinating Teams initiated by Navy Family Service Centers began in several commands. These committees differ structurally and functionally from the medical committees developed through the BUMED Instruction. Chaired by the director or a staff member of a Navy Family Service Center, these committees include a wide range of command representatives and service providers. At the time of the site visits, these base committees were planning to develop a community response to abuse and neglect through better interagency cooperation

and to sponsor educational activities aimed at command personnel and family members.

Program Operation

Case Identification. The BUMED Instruction assumes that a viable Family Advocacy Program will develop clear, routine channels for reporting incidents along with community awareness and understanding of the prevalence and nature of domestic violence and sexual assault. Although progress is being made, neither of these objectives is being met fully in either civilian or military communities. Some of the 13 Navy and Marine Corps bases visited during the study had just begun to establish community education programs and to develop defined reporting procedures.

The vast majority of family advocacy cases handled through the Family Advocacy Program surface through medical channels, primarily from the emergency room, or from pediatric or other medical officers. Although hospital personnel usually are more aware of reporting requirements than other base personnel, a significant number expressed a need for more in-service training in family advocacy case identification and management. In addition, a number of medical personnel expressed confusion about the role of the Family Advocacy Representatives and purposes of the Family Advocacy Committees.

Outside the hospital, the greatest awareness of family advocacy issues and reporting requirements is found among Navy and Marine Corps Family Service Center staffs. However, Family Service Center staffs at some bases express reluctance to report cases to the hospital, especially spouse abuse cases, primarily because of the unclear impact of case reports, the secondary nature of abuse to other family problems, and perceived potential violations of client privacy.

Interviews with other agency representatives demonstrated wide variations in knowledge about advocacy issues and reporting procedures. In most

cases, client confidentiality supersedes family advocacy reporting requirements.

Intake and Assessment. According to the BUMED Instruction, the Family Advocacy Representative is responsible for gathering background information on a family advocacy case, and presenting it to the working committees for disposition. In the Family Advocacy Representative's absence, the Duty Family Advocacy Representative, a rotating position drawn from a roster of "on call" personnel provides intake services.

The importance of the intake and assessment process lies in its impact on case disposition, diagnosis, and the subsequent design of effective intervention strategies. The inability to perform a proper case assessment because of lack of time and staff resources often delays the Family Advocacy Committee from executing its function or forces it to make case decisions without a sound basis.

Caseflow as outlined in the Instruction seems relatively straightforward--medical officers or other command personnel transfer information to the Family Advocacy Representative who logs the information and conducts an interview and initial assessment. The Family Advocacy Representative then brings the case to the committee's attention. In actuality, however, there are variations in this flow at the 13 sites. In general, intake and assessment processes are most effective when cases originate within the hospital setting; the problem involves child maltreatment, the incident occurs in CONUS; and when the Family Advocacy Representative has adequate time or staff resources to devote to the process.

Intervention and Prevention. The Enclosure to BUMED Instruction 6320.57 provides operational guidelines for family advocacy intervention and prevention. Patterned after the medical model, the Instruction specifies three levels of program intervention: primary, secondary, and tertiary.

At present, tertiary intervention in abuse and neglect cases is the major focus of family advocacy personnel. Family Advocacy Representatives recognize their responsibilities for prevention activities, but their efforts are aimed primarily at families where abuse or neglect already has occurred. Family advocacy personnel usually attribute the lack of secondary and primary intervention activities to shortages of base and community service resources and staff.

Regardless of the balance between primary, secondary, and tertiary intervention activities at the base level, most respondents recommend increasing the prevention focus of the local Family Advocacy Program. They are less specific, however, about how to turn the concept of prevention into program activities.

The BUMED Instruction provides very general guidelines for service intervention in family advocacy cases. It states that the most effective method of treatment intervention is behavioral, which focuses on the need to train individuals to use constructive methods to deal with stress and conflict. Although this statement reflects an orientation toward treatment and a goal of intervention, it does not provide personnel involved in family advocacy with clear-cut service response methods.

Although most respondents believe that "stopping the abuse or neglect" is a major goal of intervention, they are less clear about related service strategies. For example, family advocacy personnel often disagree over whether to remove the abused or the abuser from the home, whether the abused or the abuser should be the focus of intervention, or how the Family Advocacy Committee should proceed in a case where the victim is reluctant or unwilling to seek outside assistance.

Although respondents may disagree about the best response to abuse and neglect, they prefer a treatment to an administrative response to these cases. With the exception of sexual assault and rape, Family Advocacy Committee members often choose not to involve the sponsor's Commanding

Officer in abuse and neglect cases unless the family member fails to follow committee recommendations.

In most base situations, family advocacy personnel have limited resources for intervention. In fact, they note the lack of such resources as a recurring frustration. For example, although the Family Service Centers and Alcohol Rehabilitation Services often provide a major Family Advocacy Program resource, neither are present on all bases. In addition, some Family Service Centers are limited to information and referral services and lack clinical staffs.

Most military-sponsored services that are fully staffed and capable of assisting in family advocacy are located on larger bases. Overseas locations rarely have the needed treatment resources. Even in communities where civilian support services augment base resources, obstacles, such as jurisdictional issues, sometimes prevent coordination and adequate response to abuse and neglect cases involving military personnel and families.

Jurisdiction. The question of who has legal authority in a given situation is an extremely complex issue at many bases. Authority for intervention depends upon the location of the incident, military or civilian status of the victim and perpetrator, the severity of the incident, and the types of agreements existing between potential intervenors. Jurisdictional issues vary considerably across bases. Status of forces agreements and the reporting protocols in child maltreatment cases, especially in areas of exclusive juridiction, may present major roadblocks to effective service response.

Interorganizational Cooperation. The BUMED Instruction recognizes the importance of interorganizational cooperation among medical, line, and civilian agencies to program success. Although Family Advocacy Committee members usually report effective cooperation between base and community organizations in responding to abuse and neglect incidents, the degree of

cooperation varies across organizations and across sites. At those bases where linkages between agencies are more developed, there are several factors at work:

- The Family Advocacy Program has clear and established objectives;
- The Family Advocacy Representative has established liaison with people in other service agencies, both military and civilian;
- The network of agencies involved with the Family Advocacy Program is larger and includes not only the medical facility, but also available base and community agencies; and
- The Family Advocacy Representative maintains open communication channels with base and community agencies.

These observations indicate that interorganizational linkages are built largely upon good communication and a clear understanding of Family Advocacy Program tasks and objectives. The success of the Family Advocacy Program depends on various agencies providing information about abuse and neglect incidents through medical reporting channels, so that the Family Advocacy Representatives can coordinate an effective service response. Interorganizational cooperation also depends on a two-way flow of information in which base and community personnel receive feedback about case disposition and service response.

Case Reporting. At all 13 sites, abuse and neglect cases are being reported to the Family Advocacy Representative by a variety of civilian and military agencies and individuals. However, reporting procedures are more institutionalized at bases with a more established Family Advocacy Program.

Child maltreatment and sexual assault and rape cases are more likely to be self-referred or reported through Family Advocacy Program channels than those dealing with spouse abuse. This reflects the continuing ambiguity about handling spouse abuse and the precedence for reporting child

and sexual abuse. Not only do spouse abuse cases surface at a wider range of agencies and referral sources, but also base personnel feel less obligated to report spouse abuse cases and often leave the reporting decision to the abused spouse.

Reporting from one military installation to another when sponsors are transferred is often a problem area. Although most Family Advocacy Representatives indicate that they are forwarding records in the majority of established cases, they report receiving only a small number.

Follow-Up Procedures. Procedures for the follow up of family advocacy cases are an essential component to effective management of abuse and neglect cases and are discussed in several sections of the BUMED Instruction. The Instruction specifies that the Family Advocacy Representative and the Family Advocacy Committee members are to establish internal reporting and follow-up procedures. This consists of providing treatment recommendations and maintaining periodic contact with the family to insure that no further indications of abuse or neglect occur. As interpreted in the field, follow-up procedures usually refer to tracking the case after referral to treatment facilities. In general, case follow up often is hindered by shortages of staff resources and inadequate criteria for changing the status of a case from active to inactive.

Program Evaluation. The Instruction recommends systematic program evaluation and specifies that the success of the program rests on its ability to evaluate and redirect current resources in a manner that maximizes medical care to Navy and Marine Corps members and families.

Across the installations visited, however, there are few efforts to evaluate the effectiveness of the local Family Advocacy Program. The Family Advocacy Representatives and Family Advocacy Committees generally assume that the program is working if there is an increase in reported cases. This informal assessment is often skewed, however, because records involving family violence or sexual abuse have been kept systematically only in the past few years. As a consequence, comparison figures for the

rate of abuse and neglect across a specified time period may reflect more improvements in case identification and record keeping than an actual increase in the number of cases. Only a few bases have the necessary case records to estimate realistically the effects of the program.

Program Recommendations

During the site visits, respondents were asked to offer specific recommendations for strengthening the Family Advocacy Program on their bases. They were asked to make these recommendations while assuming two different situations: the possibility and the impossibility that base resources and staff would be increased to respond to abuse and neglect cases. Their recommendations include:

- Increasing the number of Family Advocacy program staff;
- Increasing abuse and neglect prevention efforts, including more community education in family advocacy issues and greater outreach to families under stress;
- Providing greater program guidance especially around issues of interorganizational liaison, case disposition, and reporting procedures;
- Providing additional family advocacy training, especially in the area of case identification and assessment;
- Encouraging more active involvement of the sponsor's Commanding Officer in abuse and neglect cases; and
- Conducting better prescreening before overseas assignments.

CONCLUSIONS

In reviewing the assessment data across installations, SRA project staff identified current program strengths as well as the concerns and dilemmas facing Family Advocacy Program and related base personnel. Factors associated with Family Advocacy Program effectiveness also are discussed.

Program Strengths

Despite variation in Family Advocacy Program development and sophistication across installations, bases share certain strengths in their response to abuse and neglect. For example, medical personnel at most locations visited have responded to the BUMED Instruction and established policies and procedures for handling abuse and neglect cases. Although some program efforts are more developed than others, medical and base personnel generally share a pro-family advocacy stance and demonstrate program initiative and flexibility. Other program strengths include:

- **Competent and Professional Staffs.** Although the number and expertise of support personnel vary, most base and medical personnel demonstrate an awareness of abuse and neglect dynamics and are attempting to coordinate service response.

- **Program Responsiveness.** Despite professional resource limitations at some bases, Family Advocacy Program personnel at each base have initiated policies and protocol for identifying and coordinating service response to abuse and neglect cases.

- **Case Successes.** Program personnel report a number of successes in resolving abuse and neglect situations.

- **Interagency Cooperation.** In general, a solid foundation has been laid between Family Advocacy Program representatives and other base service providers.

- **Availability of Civilian Resources.** At most CONUS installations visited, base resources are augmented by civilian services and programs.

- **Established Emergency Room Protocol.** To facilitate program response, clear guidelines for handling abuse and neglect cases are posted in most base medical centers.

- **Command Support.** With few exceptions, both hospital and base leadership recognize the threat that abuse and neglect pose to personal, family, and community well-being and they support Family Advocacy Program efforts.

- **Positive Impact of Family Advocacy Training.** The recent family advocacy training workshops attended by medical and line personnel have facilitated cooperation between medical and base service providers.

- **Foundation for Program Development.** Although the developmental status and sophistication of Family Advocacy Programs varied across bases, each base has developed a foundation for improving prevention and intervention services in areas of abuse and neglect.

Areas of Concern

The Family Advocacy Program is confronted today by a number of concerns that are best described as developmental. For example, the increasing number of family advocacy cases have not necessarily been paralleled by increases in program staff and resources. As a consequence, case assessment and disposition is hindered at some bases by an increasing backlog of

cases. This and other concerns identified during the site visits are outlined below:

- **Lack of Program Clarity.** Despite the program detail provided in the BUMED Instruction, base and medical personnel often are unsure of the goals of the Family Advocacy Program, the role of the Family Advocacy Committees, and the responsibilities of the Family Advocacy Representative.

- **Family Advocacy Representative as a Collateral Duty.** The amount of time the Family Advocacy Representative devoted to Family Advocacy Program-related duties often is insufficient given program responsibilities.

- **Role Ambiguity Between the Family Advocacy Representative and Family Service Center Staff.** Lack of effective liaison and coordination between the Family Advocacy Representative and the Family Service Center staff promotes duplication of efforts and confuses base service providers about appropriate referral protocol.

- **Insufficient Assessment and Treatment Resources.** Although procedures for case identification have often improved at bases, staff resources for case assessment and treatment have remained relatively constant.

- **Diagnostic Emphasis.** Because of time devoted to discussing case diagnosis, the focus and energy of Family Advocacy Committees often are diverted from developing treatment strategies and followup procedures.

- **Lack of Training in Program Development.** In general, medical and base personnel demonstrate limited knowledge about how to develop a coordinated service response to abuse and neglect issues that minimizes program duplication and maximizes program effectiveness.

- **Child Maltreatment Focus.** At the bases visited, program attention and response more often are directed to child maltreatment than to spouse abuse or sexual assault and rape.

- **Program Procrastination.** In some cases, Family Advocacy Program participants attribute program inertia to the anticipation of a new line Instruction or to the scheduled opening of a base Family Service Center.

- **Confusion about Procedures for Case Reporting to Gaining Medical Commands.** Although most Family Advocacy Representatives report forwarding case materials to the gaining medical facility when a family advocacy case relocates, few reported receiving such notification.

- **Failure to Understand the Full Scope of the Family Advocacy Program.** Medical and base personnel, even Family Advocacy Representatives and Family Advocacy Committee members, often are unsure of the impact of establishing an abuse or neglect case on the sponsor's career and how case reports are processed at the Washington level.

- **Reactive Orientation.** Although the BUMED Instruction suggests that family advocacy intervention should incorporate both prevention and treatment services, base programs focus more on responding to existing abuse and neglect cases than on preventing new cases.

- **Working Relationships with Civilian Child Protection Services Units.** Although in some situations, Child Protection Service workers share incident reports and the results of child maltreatment investigations with the Family Advocacy Representative, at other bases the Child Protection Service workers will not provide feedback in child maltreatment cases involving Navy or Marine Corps personnel or dependents without a signed release of information.

Program Dilemmas

Other issues facing the Family Advocacy Program are not necessarily program concerns, but require choices between potentially equally justifiable alternatives. In some instances, these dilemmas arise from policies and procedures beyond the control of Family Advocacy Program staff; in other instances, they involve making program and case decisions within policy, resource, and legal parameters. They include:

- **Notification of Commanding Officers.** Medical and base personnel often differ concerning when or if to notify the sponsor's commanding officer in abuse and neglect cases.

- **Guidelines for Establishing a Case.** There is little consensus about what constitutes established abuse and neglect.

- **Case Confidentiality/Privacy.** In some situations, base personnel are reluctant to refer cases through the Family Advocacy Program because they consider information between the client and themselves as confidential.

- **Staff Credentials for Treatment.** Medical and service professionals often differ about the necessary qualifications for treating victims and perpetrators of abuse and neglect.

- **Response to Dependents/Department of Defense Personnel Overseas.** Because military personnel have limited authority over military dependents and Department of Defense personnel overseas, they often depend upon the host government to exercise jurisdiction in problem situations. Unfortunately, authorities in both Japan and Italy are reluctant to become involved in family disputes involving American citizens.

- **Relationships Between Clinics/Dispensaries and Navy Regional Medical Centers.** In some locations there is little defined

interface between levels of medical facilities in terms of case consultation or reporting procedures.

- **Role of Family Service Centers in Family Advocacy.** At the present time, there is wide variation in the role of Family Service Centers in the Family Advocacy Program. Both medical and Family Service Center personnel express a need for clearer delineations of their respective roles in the Family Advocacy Program.

- **Base Need for Shelters/Safe Houses.** Base and medical personnel often are divided over the merits of base shelters and safe houses.

- **Punishment Versus Rehabilitation.** At present, there is a lack of established criteria about if and when abuse and neglect cases should be handled through punitive rather than treatment rehabilitation channels.

Keys to Success

There are a number of prerequisites for developing and maintaining an effective and responsive program. The elements that make up a successful program appear to include:

- **Command Support and Concern.** Both hospital and line commands need to recognize the impact of dysfunctional families on mission readiness and support Family Advocacy Program personnel, the Family Advocacy Representative in particular.

- **Program Clarity.** Programs must establish well defined procedures for case referrals, intake, assessment, and disposition, and continually educate non- Family Advocacy Program personnel about these procedures.

- **Collaborative Team Approach.** Because of the multiple factors involved in abuse situations, intervention strategies call for combined expertise from a number of disciplines or specialities.

- **Family Advocacy Program Leadership.** Energetic and committed Family Advocacy Representatives who view themselves as program managers as well as clinicians provide a focal point needed by other program participants.

- **Effective Liaison with Civilian Child Protection Service Units/ Local Authorities.** Effective communication channels between Family Advocacy Program personnel and personnel in civilian agencies lead to more informed committee decisions and better developed intervention plans.

- **Quality Staff.** The more all program staff are familiar with the dynamics in abusive families and sexual assault/rape situations and the range of treatment alternatives, the better the change of successful outcomes.

- **Family Advocacy Committee Membership.** Those committees which draw their membership from the widest array of individuals and organizations function most effectively.

- **Proactive Focus.** Command and community awareness of family advocacy issues and the family advocacy program are essential for maintaining effective response.

- **Presence of Family Service Centers.** Although Family Service Centers are not the only service resource for family advocacy clients, they are often essential for providing information, referral, and counseling services. They also constitute a primary link with the line community.

- **Availability of Support Facilities.** Because medical facilities do not have the staff resources necessary to meet family advocacy cases, a wide array of alternatives, both civilian and military, must be available and utilized.

- **Training Experiences/Opportunities.** Personnel associated with the Family Advocacy Program and with Family Advocacy Representatives in particular need ongoing training and networking opportunities with other professionals in both case management and the dynamics of family violence.

- **Program Flexibility.** Each individual program must be able to ascertain the full extent of its potential resources and design appropriate procedures for its own locale.

Overall, assessment results suggest that the Family Advocacy Program currently is in a state of transition. Although bases are attempting to refine their policies and procedures and improve service response, program efforts are hampered by lack of program clarity, program staff, and community resources for assessment and intervention.

APPENDIX C

CHILD MALTREATMENT IN THE MILITARY: A STATUS REPORT

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Child maltreatment is not a new phenomenon in Western society. From colonial times to the present, an examination of court records, newspaper articles, and laws suggest that children have been killed, beaten, abandoned and sexually assaulted. In fact, the further we go back in history, the harsher and crueler appears to have been the situation of children.

What is new, however, is the increasing concern directed toward child maltreatment in this country and overseas. The various military services have not been exempt from this concern. During the last two decades, numerous research studies, legislative initiatives and conferences have been held on selected aspects of child maltreatment. In addition, services and programs have been implemented in both the civilian and the military communities to protect children and to work with perpetrators of abuse and neglect.

It is now realized that the consequences of maltreatment extend beyond the destruction faced by individuals and families. Brutalizing childhoods are characteristic of juvenile delinquents, murderers, rapists, split personalities, and batterers of the next generation of children. Cases of child maltreatment also strain our medical, human service, legal, and judicial resources.

In the military community, child maltreatment can seriously impair the job performance and operational readiness of the member, whether he/she is involved directly or indirectly. The link between family well being and support and job productivity and retention in the military is well established.

Child maltreatment also affects the military community in a more indirect way. Intergenerational links are central to the recruitment and retention of military personnel. Children who are maltreated and later join the military are likely to perpetuate the occurrence of child maltreatment in the military community, display dysfunctional coping styles, and strain the human service delivery system.

In spite of widespread interest and concern and the potential consequences of child maltreatment, the real incidence of child maltreatment is still unknown, and its underlying dynamics remain insufficiently understood. This is especially the case, however, in the military services.

A number of significant gaps remain in the literature. Although neglect is the most common type of child maltreatment, research has focused primarily on physical abuse. Interest in sexual abuse is comparatively recent, and to date little is known about this subgroup of abused children. Despite the extent of adolescent maltreatment, little information is available on the nature of this problem and the characteristics of the victims and their families.

Although the issue of child maltreatment in the military was recognized early in the study of child maltreatment, research on the problem among military families is scattered and unsystematic. Little specific research has been conducted either on the incidence of child maltreatment in the military or on factors associated with its occurrence.

This article examines the scope and nature of child maltreatment in the military community by summarizing the available literature. The intent is to provide a brief status report of current knowledge about its incidence, dynamics, and treatment and prevention. Because of the existing limitations in military literature, data from the civilian population provides the basis for this discussion. Findings from the military community are provided where available, and extrapolations are attempted from the civilian to the military population.

Incidence

For the past decade, the incidence of child maltreatment among military families has been a topic of much debate, but little conclusive data.

Although each of the services has established a system for reporting child maltreatment incidents, many cases go unreported because of time constraints, concerns about confidentiality and career consequences for perpetrators, and ineffective liaison between military branches and between the civilian and military communities. These problems seriously challenge the validity and reliability of available estimates of child maltreatment in the service branches. In addition, they make comparison of incident rates between the military and civilian sectors questionable, at best.

Despite these problems, the military services reported approximately 1,500 cases of child maltreatment in 1977 and projected 1,900 cases in 1978. It is likely, however, that these figures are low due to underreporting. Based on recent findings, for instance, the National Center on Child Abuse and Neglect (1980) estimated that 10.5 children are maltreated annually for each 1,000 children in the United States younger than 18 years of age. If this figure is extrapolated to the military population, this means that approximately 15,500 children are abused and neglected annually. This estimated total is considerably higher than the 1,500 cases of maltreatment reported in 1977.

Based on theory, rudimentary evidence and comparison of factors associated with maltreatment, it has been suggested that child maltreatment in the military may be as high or higher than the incidence in the general population. On the other hand, justification and preliminary evidence also exist to suggest that child maltreatment may be lower in the military than in the civilian sector. Given the problems of the military reporting system and the lack of comparable data, however, there is little basis for either claim. Until further research is conducted, the military services must continue to rely on extrapolations from civilian figures.

Factors Related to Child Maltreatment

What distinguishes the abusing family from the nonabusing one? Most people who have maltreated their children are not mentally ill or even parents who do not love their children. As a group, they defy psychiatric classification and cover the entire socioeconomic and educational spectrum. How then do child maltreaters differ from parents who do not abuse their children?

Although studies from the military and civilian communities suggest that child maltreatment varies across a number of demographic, individual, relational, and situational factors, several factors are particularly relevant to the military community: family demographics, stress, and social isolation.

One distinction between abusive and nonabusive families lies in their demographic characteristics. Compared to nonabusing parents, for instance, child maltreaters tend to be younger and of lower socioeconomic status. In addition, abusing parents are more often high school graduates than parents with more or less education. Given the demographic profile of the military population, these findings are especially relevant. In the military community, more than half of active duty men are aged 30 or younger compared to one-quarter of males in the civilian community. In addition, a high percentage of these personnel are married and have young children. Lastly, more than half of the service members have completed only high school and financial hardships are a difficulty for many military families, especially among those in grades E-4 and below. Because of the parallels between the demographic profile of the military population and those of child maltreaters in the general population, there is ample justification for defining military population as a "high risk" group for child abuse and neglect.

Stress is an overriding problem for many parents who abuse and neglect their children. Some of the family stresses most often associated with child maltreatment include large family size, financial hardship,

pregnancy, prematurity of the child, job dissatisfaction, and single parenthood. The link between family stress and child maltreatment is especially pertinent to the military community given the nature of the military lifestyle which requires constant readiness and high mobility. Military families experience frequent separations and often long-term separations from extended families and friends. Working with other stress factors, situations can result that are conducive to the occurrence of child maltreatment.

Social isolation is another factor that often is associated with abusive parents. Child maltreaters tend to be socially isolated from formal and informal social networks such as parents, friends, neighbors, and community services. In addition, few of them are engaged in social or recreational outlets.

The relationship between social isolation and child maltreatment has special significance for military family life. Recent studies suggest, for instance, that military families are highly self-reliant. Although this self-reliance can be viewed as a healthy response to the frequent moves and transitions experienced in the military, it can leave families very vulnerable to stress and open to dysfunctional coping patterns such as child maltreatment. In addition, families who are socially isolated are less likely to be influenced by community expectations or to modify their behavior in response to those expectations.

Current research also suggests a number of other factors that differentiate abusing from nonabusing parents, such as alcohol abuse and marital discord. It is likely that the factors associated with child maltreatment interact in complex ways to create a situation conducive to the various forms of abuse and neglect. Although efforts are underway to better understand this interplay, developing these factors into an operational model of protection, prevention, and intervention remains a challenge.

Treatment and Prevention

Since the 1970s, extensive legislation and services have been implemented to protect children and to work with perpetrators of abusive acts against children. In addition, child protection policies and programs have developed in each of the service branches to prevent and treat child maltreatment. Sexual assault against children also has emerged as a focus for the human service and criminal justice system.

Literature in the field shows a predominance of information on the incidence and dynamics of child maltreatment. Comparably less is available on successful program models and components. Descriptions of operating programs tend to be fragmented and difficult to locate. This limits the sharing of expertise and the replication of successful program development and intervention techniques.

Although the importance of community intervention into the problem of child maltreatment is recognized, there are no simple solutions. Child maltreatment is a complex problem. Its causes are numerous and vary among individuals and groups of individuals. Accordingly, no single response will substantially reduce the incidence of child maltreatment.

No one agency or service system has all the resources to deal with all aspects of the child maltreatment problem. Treatment and prevention of child maltreatment are promoted by a coordinated, interdisciplinary interagency response. In fact, the more integrated the service approach, the more comprehensive and cost effective the response to child maltreatment. Programs involving community education, home visitation, crisis, emergency and long term treatment, day care services and residential care, outreach interviews, family-focused counseling, support services, and effective case management appear instrumental to developing an effective response to child abuse and neglect. Parent education and support groups may also be helpful.

Conclusion

American society has often been described as child centered. This idealized image, however, is contradicted by the prevalence of child maltreatment in the United States. Child maltreatment not only poses a serious threat to the growth and development of its victims, but also challenges the very foundations of family integrity and social stability.

The seriousness of child maltreatment demands continued attention. Researchers and human service professionals must continue to explore the complexities of this problem. Only then can programs and services be built on facts rather than assumptions, real needs rather than assumed needs.

APPENDIX D

SPOUSE ABUSE IN THE MILITARY: A STATUS REPORT

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Spouse Abuse in the Military: A Status Report

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Both anecdotal and historical data confirm that the family has long been a scene of interpersonal violence. For the most part, however, abuse has suffered from selective inattention. The victims have been among the missing persons in the literature on social problems and criminal violence. In the late 1960s and early 1970s, however, the issue of spouse abuse was transformed from a private issue to a public problem. Demands from human service professionals and citizen groups increased for expanded social services and new and criminal protection for abused wives. Between 1975 and 1980, 44 States passed new legislation addressing domestic violence.

The military services have not been exempt from increasing focus on spouse abuse issues. In recent years, military conferences have been held focused exclusively on spouse abuse issues and each military service branch has expanded their existing child advocacy program to include policy and guidance on spouse abuse. The expansion of child advocacy programs in the military services to include policy and guidance on spouse abuse was a logical extention because both child and spouse abuse are forms of domestic violence and because both may occur within the same family. At the same time, adding spouse abuse to child advocacy programs complicated the jobs of family advocacy professionals in the military. The prevention and treatment strategies for spouse abuse are quite different from those used in child abuse. In addition, there are state-mandated and funded mechanisms, such as protective services, that can support military efforts for child abuse; analogous services often do not exists for battered adults.

It is now realized that the consequences of spouse abuse extend beyond the obvious injuries experienced by the victims of spouse violence. Women who experience repeated physical assaults at the hands of their husbands tend

to have lower self-concepts than women whose marriages are free of violence. Battered women also may develop an inability to protect themselves from future assaults. In addition, repeated assaults may diminish a woman's belief that she is capable of controlling the events that go on around her. Such a belief of "learned helplessness" is frequently used to explain the reluctance of abused wives to leave their battering husbands. Women who experience "learned helplessness" may believe that killing their husbands is the only escape from victimization.

Spouse abuse influences the family in other ways as well. Researchers have found that one form of family violence tends to be linked with other forms of family violence. A family with spouse abuse also is at risk for child abuse and even of children assaulting their parents. In addition, children who grow up observing their mothers being physically assaulted are more likely to abuse their own children and their own spouses. Thus, a consequence of spouse abuse in one generation is that it can initiate a cycle of violence that repeats itself in the next generation.

The consequences of spouse abuse for society include the days lost from work by victims of spouse abuse and the extra burden it frequently places on the medical care system. Research also has shown that domestic disturbance calls constitute the single largest category of police calls. Police officers are more likely to be killed answering a domestic disturbance call than performing any other type of police work--including chasing armed robbers. Although there is no precise data on whether spousal violence leads to mental and psychological problems for its victims and other members of the family, it is at least plausible that it does. Such potential impacts compound the costs of spouse abuse for the individual, for the family, and for the medical and social service system that responds to these problems.

In the military community, the potential costs of spousal violence include the possibility that domestic problems may reduce the efficiency of the active-duty spouse and thus affect morale, performance, readiness, and personnel retention. The link between family well-being and support and

job productivity and retention is well established in the military manpower literature. If the victim is a female active-duty member, it is reasonable to assume that their productivity will be affected directly. Cases of domestic violence also may strain the medical, human service, legal, and judicial resources in the military community.

Despite widespread interest and concern and the potential consequences of spouse abuse, there remain a number of important gaps in the knowledge about spouse abuse. First, little specific data exist on the incidence of spouse abuse. Unlike the problem of child maltreatment, there are no state regulations concerning mandatory reporting of spouse abuse by physicians or other professionals. Consequently, reliable data is lacking on the incidence of spouse abuse within the general United States population. There is even less information available on the incidence of spouse abuse in the military population. Second, there is insufficient information on the dynamics and sequence of events leading to marital violence. Much of the past research, for example, has focused on the violence of husbands against wives. There is good reason for this emphasis. Researchers conclude that husbands use the most dangerous and injurious forms of violence; violence by husbands more often results in physical injury and is repeated more than violence by wives. Evidence also suggests that violence of wives toward husbands is often self defense or is a response to blows initiated by husbands. Lastly, a large number of attacks occur when the wife is pregnant, thus posing a danger to the unborn child. Still, violence on the part of wives toward husbands does occur and requires additional research.

Lastly, little rigorous data are available that evaluate the effectiveness of interventions in instances of marital violence. Although shelters often are considered a significant and cost-effective intervention, for example, little data exist on either the short- or long-term effects of women leaving an abusive spouse and spending time in a women's shelter or safe house.

This article examines the scope and nature of spouse abuse in the military community by summarizing the available literature. The intent is to provide a brief status report of current knowledge about its incidence, dynamics, and treatment and prevention. Because of the existing limitations in the military literature, data from the civilian population provides the basis for this dicussion. In addition, although recognizing that husband abuse does occur, this review focuses primarily on spouse abuse where the wife is the victim.

Incidence

Because violence between husbands and wives was traditionally hidden in the home, there has been a general lack of awareness of the seriousness and the extent of the problem. Moreover, unlike child abuse and neglect, no official agencies have been mandated to record the incidence of spouse abuse. In the military, although each service has established a system for reporting spouse abuse cases, many cases go unreported because of time constraints, concerns about confidentiality and career consequences for perpetrators, ineffective liaison between military human service providers, and lack of coordination between military service branches and between the civilian and military communities. Nevertheless, a variety of data sources suggest that spouse abuse is far more extensive than commonly assumed.

Investigators frequently make use of indirect measures of spouse abuse incidence, such as the percentage of homicides which involve domestic killings, number of aggravated assault cases between husbands and wives, and the number of cases of battered spouses treated by hospital emergency rooms. Estimates of spouse abuse based on indirect measures range from thousands to as high as 28 million abused spouses. At best, however, these figures are crude estimates and are limited by definitional problems of what constitutes abuse, use of unofficial data, and reliance on small and nonrepresentative samples.

One study which was based on a large nationally representative sample of families was conducted in the mid-seventies. Adopting a standard deviation of violence as an act carried out with the intention or perceived intention of physically hurting another person, the investigators based their estimates of violence and abuse on self-reports of a nationally representative sample of 2,143 individual family members.

In 16% of those surveyed, some kind of physical violence between spouses had occured during the year of the survey, while 28% of those interviewed reported marital violence at some point in their marriage. In terms of acts of violence that could be considered wife-beating, the national survey revealed that 3.8% of American women were victims of abusive violence during the 12-month period prior to the interview. Applying this incidence rate to the approximately 1,095,000 member and civilian wives in the military community, this means that approximately 42,000 wives in the military communities are potentially abused annually.

The same survey found that 4.6% of the wives admitted to, or were reported by their husbands as having engaged in, violence directed toward their husbands. The data on husbands, however, does not adequately represent the actual extent of the phenomena of husband abuse. First, the researchers point out that in a large number of instances, the wives' act of violence were in response to violent assaults by their husbands. Secondly, women who struck their husbands are thought to be less likely to harm their husbands than men who used the same forms of violence toward their wives. Overall, available data suggest the American family as one of society's most violent institutions.

Factors Associated With Spouse Abuse

During the past 10 years, studies of spouse abuse in the military and civilian communities have uncovered a number of demographic, individual, relational, and situational variables associated with the use of violence between husbands and wives. This section draws upon empirial studies and

reviews of literature to outline and briefly describe some of the most salient factors that have been associated with spouse abuse.

Age. Researchers report that violence between spouses occurs most often in younger families. The rate of spouse abuse for husbands and wives 30 years of age or younger, for example, is more than twice that of the next group, 31 to 50 years old.

Duration of Relationship. Although marital violence occurs across the marital life cycle, it is somewhat more concentrated in newer marriages (less than 5 years).

Socio-economic Status. Spouse abuse is found in families across the spectrum of socio-economic status, but it is more prevalent in lower socio-economic status families.

The Cycle of Violence. One of the consistent conclusions of family violence research is that individuals who have experienced violent and abusive childhoods are more likely to grow up and become child and spouse abusers than individuals who have experienced little or no violence in their childhood years.

Personality Characteristics of Batters. Batters often display low self-esteem, a sense of helplessness and inadequacy, high dependency needs, and conflicts over being emotionally dependent.

Personality Characteristics of Abused Women. Although the literature suggests that abused women often are dependent, have low self-esteem, feelings of inadequacy and helplessness, research on personality characteristics of abused women is difficult to interpret. It is never clear whether factors cited are the cause or effect of victimization.

Marital Dynamics. Abusive couples often demonstrate poor communication skills, emotional restriction, low tolerance for stress, and unrealistic marriage expectations.

Alcohol. Studies of the relationship between alcohol use and spouse abuse typically find alcohol abuse occurring in one-third to one-half of the time in men who batter.

Mental Health. Case reports in marital violence provide evidence that spouse abusers often are exemplary citizens in all other aspects of their lives.

Power Distribution in the Family. Violence toward wives is much more common in homes where the power of decision-making is concentrated in the hands of the husband. The least amount of violence toward wives occurs in households where husbands and wives share decision-making responsibilities.

Family Stress. A recurrent finding in domestic violence research is the strong association between spouse abuse and family stress (e.g., financial problems, pregnancy, large family size, and poor housing).

Social Isolation. Spouse abuse is more common in families that have weak ties to formal and informal social support networks such as parents, friends, neighbors, and community services.

Current research also suggests a number of other factors that are associated with spouse abuse, such as low job satisfaction and lack of religious affiliation. It is likely that the factors associated with spouse abuse interact in complex ways to create a situation conducive to marital violence. Although efforts are underway to better understand this interplay, developing these factors into an operational model of protection, prevention, and intervention remains a challenge.

Treatment and Prevention

Recognition of spouse abuse both as a widespread social problem and as a public issue was sparked by activities of community-based women's groups in this country and England. The programs generated during the past decade have focused primarily on the victim rather than on the abuser. They have centered on the development of emergency and short-term shelters for victims and their children, counseling, and other support services. Although responding to victims of ongoing violence has received service priority, increased attention is now being directed toward the development of prevention services including public awareness and education programs.

Effective program and intervention strategies are based on a clear understanding of the dynamics of battering and the social, cultural, and interpersonal factors that contribute to the problem. Regardless of the model used for delivering services, however, the primary goal of most programs is to ensure the safety of the victim(s) and to stop the battering or violence.

Families involved in domestic violence may need one, some, or all of the following types of assistance: immediate help; protection and physical safety; basic material needs such as medical and dental care, emergency financial aid, housing, food, clothing, and child care; emotional and psychological support; helping resources such as legal aid, job training, employment services, parent education, and family planning; crisis intervention and the availability of 24-hour service; emergency room treatment which focuses on accurate identification, diagnosis, treatment, and referral; and offender services which are sometimes sought voluntarily or mandated through the criminal justice system.

A comprehensive service delivery system requires all program components to function in an integrated manner. Both internal and external coordinating mechanisms are necessary for referral and maintenance of liaison between staff, program, and systems involved in case management.

Conclusion

The issue of spouse abuse received public attention somewhat later in both the civilian and military sectors than did child abuse. Although prevention and treatment programs for spouse abuse are being initiated, information on its trends and dynamics remain inadequate, especially in the military services.

The military structure, with its high degree of organization and clear lines of authority, is a potential strength in the implementation and management of service delivery. The many support systems the military provides for its families have the potential for helping to reduce family stress and reduce or prevent spouse abuse. The organizational structure of the military also is conducive to formal program evaluation and data analysis to determine program impact, as well as gather information on the nature and extent of the problem in the military services.

Military researchers and human service professionals must continue to explore the complexities of spouse abuse. Only then can programs and services be designed that effectively treat and prevent spouse abuse and, as a consequence, enhance military preparedness.

APPENDIX E

THE EVOLVEMENT OF FAMILY ADVOCACY PROGRAMS IN THE AMERICAN MILITARY: A STATUS REPORT

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THE EVOLVEMENT OF FAMILY ADVOCACY PROGRAMS IN THE AMERICAN MILITARY: A STATUS REPORT

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The official establishment of family advocacy programs in the American military, programs designed to respond to family violence, paralleled growing public concern over reports of increases in child and spouse maltreatment in our society, combined with doubt that strategies and resources for coping with these problems were adequate. It was generally recognized that such abuse posed a serious threat to family life and, within the military community, compromised military preparedness by reducing the readiness and performance of individual soldiers.[1]

This article traces the development of the family advocacy movement from the early emergence of public concern about child abuse and neglect to the establishment of formal family advocacy programs in the military services, under guidance from the Department of Defense (DoD). To accomplish this aim, it draws together public and legal documents, military instructions and directives, government evaluations, conference reports, professional research and reviews on abuse and neglect, and military and civilian responses to these problems.

The present review serves several interrelated functions. First, it provides an important foundation for the continued refinement and development of military family advocacy programs. An understanding of program history leads to better informed and more effective program decisions. Second, the review gives military family advocacy practitioners a better understanding of the history and context of their function. It is these individuals who often have little time for policy review and literature searches. In addition, many family advocacy professionals in the military may be hampered in their review from nonproliferation of reports and difficulty in locating existing reports and regulations. Lastly, it reinforces the tremendous strides made by the military services in response to abuse and neglect. The military services have been societal leaders in recognizing the seriousness of abuse and neglect and institutionalizing program responses to these problems.

EARLY CHILD ABUSE INITIATIVES AND LEGISLATION

In both the civilian and the military community, pressures for new legal and other responses concerning child abuse and neglect preceded demands for addressing spouse abuse by approximately 10 years. As published reports emerged in the civilian sector during the mid-1960s and early 1970s calling for responsive countermeasures to child abuse and neglect, similar expressions and appeals appeared in the military community. During this time, estimations of the incidence of child abuse and neglect in the military were based on limited data and experience and often were compared with civilian estimates. These estimates ranged from "relatively slight" to "abundant" and, when compared to the civilian population, from "similar to that in the general population," to "over four times greater than in the general civilian population."[2] Despite the questionable validity and reliability of these early estimates, the magnitude of the problem prompted base-level medical personnel within the services to establish formal child abuse programs.

In these original activities, the medical aspects of child maltreatment cases were the primary concern. Intervention was restricted largely to the immediate medical needs of the abused and to punitive action against the abuser. Still, it was recognized that a comprehensive approach was essential to maximize program effectiveness. Hence, programs expanded to include the total social picture of the maltreatment problem with education, prevention, intervention, treatment, and follow-up components, as well as close collaborative links with local, state and county entities.

The growth of independent base-level programs in each branch of the military, combined with recognition of the comprehensive requirements of an effective approach, made evident the need for department-wide policies and procedures for implementation of child advocacy programs. With participation from representatives of all three services, members of the military section of the American Academy of Pediatrics in March 1973 recommended that a directive be developed at the DoD level to establish a consistent method for management of abused children and their parents.

In July 1973, shortly after this recommendation was issued, representatives of the Office of the Assistant Secretary of Defense for Health and

Environment met with representatives of each branch of the military services for a discussion of maltreatment programs for military children. However, no decisions or actions emanated from this meeting.

Heavy impetus was added to the national child advocacy movement in January 1974, with Congressional enactment of Public Law 93-247, the Child Abuse Prevention and Treatment Act. The Act included a definition of the term child abuse and neglect and identified a child as one ". . . under the age of eighteen, or the age specified by the child protection law of the State in question . . . ."[3] The Act also established the National Center on Child Abuse and Neglect (NCCAN).

In June 1974, the American Medical Association (AMA) held a conference on child maltreatment in the military. Recommendations from this meeting included the suggestion that DoD select a group of experts in the field of child maltreatment to provide specific guidance on the implementation of military child abuse programs.

In partial response to this recommendation, a Tri-Service Child Advocacy Working Group was established in the Office of the Assistant Secretary of Defense for Health Affairs in January of 1975. The group was formed to monitor existing programs in the service branches. Meeting only occasionally, its membership was comprised of staff from the services' manpower communities and the Offices of the Surgeons General. These individuals participated on a part-time, collateral-duty basis.

THE DEVELOPMENT OF CHILD ADVOCACY PROGRAMS IN THE MILITARY SERVICES

The Air Force Program

The Air Force was the first service to organize an official Child Advocacy Program. Established under Air Force Regulation 160-38, dated April 25, 1975, the medical service was given primary responsibility for the program. Under the regulation, a child was defined as a dependent of a military member or spouse who either had not passed his/her twenty-first birthday or who was incapable of self support.

Policy and program responsibility for the Air Force program was given to the Surgeons General. The Surgeons General was charged with: providing policy and program guidance; establishing a headquarters Child Advocacy Committee and identifying a chairman; and coordinating the medical, psychological, and sociological aspects of the program with other relevant federal agencies and professional organizations. The headquarters committee was given responsibility for evaluating and coordinating program activities at the headquarters level and recommending policy and program changes. Committee membership included representatives from the Office of the Surgeons General, the Deputate of Personnel Plans, Chief of Chaplains, the Judge Advocate General, the Inspector General, and the Chief of Security Police. Each committee member was charged with providing collaborative assistance from their respective areas of responsibility.

The regulation extended responsibility for program monitoring and management to Major Commands, with direct responsibility delegated to the Command Surgeon. At the local base level, responsibility for the program resided with the Base Commander, with designation of this responsibility to the Director of Base Medical Services (DBMS). It required establishment of a Child Advocacy Committee at each base, chaired by the DBMS or the Chief of Hospital Services. The committee was comprised of individuals representing those units directly responsible for implementation of program components: the Child Advocacy Officer, Staff Judge Advocate, Director of Personnel, Chief of Security Police, Chaplain, and Special Services Officer. The chair was advised to encourage representatives of the local civilian child protection agency to attend meetings in an advisory capacity.

The Army Program

The Army Child Advocacy Program was formulated by a special committee appointed by the Army Surgeons General. Although it was initially conceived primarily as a medical program, the approach was broadened to include the social aspects of the problem. The original directive (AR 600-48) was issued on November 26, 1975, with the Deputy Chief of Staff for Personnel directly responsible for program implementation. Under the directive, a child was defined broadly as a dependent younger than eighteen.

Overall program management was delegated to the Adjutant General in early 1977. This change, along with refinements and more detailed specification of the duties and responsibilities of involved personnel, was issued as directive AR 608.1 dated October 1, 1978. As a result, the program was placed under the auspices of the Army Community Services Program.

At the headquarters level, the Surgeons General was required to support the program with resources and technical assistance related to providing health services; establishing a system for collecting data on cases of maltreatment; and supervising the medical and psychosocial aspects of identifying, preventing, and treating maltreatment. At this level, the Chief of Chaplains was charged with supporting program activities concerning the morale and morals of the installation community. Also the Chief of Public Affairs was responsible for coordinating information about the program, and the Judge Advocate General was charged with providing legal advice in program matters.

At each installation, the commander was required to appoint an Army Child Advocacy Program (ACAP) Officer to monitor and provide staff supervision of the program and to serve on the Child Protection and Case Management Team (CPCMT). The regulation stated that normally this appointee would be the local Army Community Services (ACS) Officer or social worker. The installation medical treatment facility officer was required to appoint and supervise the multidisciplinary CPCMT in providing evaluation, diagnosis, treatment, and disposition of child maltreatment cases. The team would consist of a pediatrician, psychiatrist, psychologist, social worker, nurse, lawyer, the ACAP Officer, and the ACS social worker. It was suggested that the team might also include law enforcement personnel, civilian

child protection workers, chaplains, and occupational therapists, as well as other personnel who might make contributions.

The Navy Program

On February 4, 1976, the Navy Bureau of Medicine and Surgery (BUMED) issued BUMED Instruction 6320.53A. This instruction provided policies and guidance for the establishment of a Child Advocacy Program within the Navy Medical Department. It defined a child as an unmarried person who either has not passed his/her twenty-first birthday, has not become legally emancipated, or is incapable of self support. The definition was later changed, lowering the age limit to children younger than eighteen.

The need for a Navy-wide child advocacy program with centralized control and guidance was apparent in the proliferation of local initiatives at base medical facilities. By 1975, all 14 regional Navy medical centers had developed child maltreatment policies or child advocacy regulations. Similar action had taken place at 19 of the 21 smaller Navy hospitals.

The BUMED instruction outlined procedures for protecting children who were abused, neglected, or abandoned. It further directed commanders to ensure that services for children receive careful evaluation and monitoring, consistent with approved local community standards.

Under the BUMED Instruction, the Navy Surgeons General had responsibility both for the Child Advocacy Program and for establishing a headquarters Child Advocacy Committee. This committee was charged with overseeing the program throughout the Navy. Although the instruction was limited to stations having medical personnel, a broader scope was implicit in specifying the membership of this committee. The regulation specified that the central committee would include representatives from BUPERS, the Judge Advocate General, the Chief of Chaplains, and the Surgeons General. In conjunction with its overseeing responsibilities, the central committee was charged with: establishing and maintaining a central registry of confirmed cases of child abuse and neglect; performing case counting and incident rate analysis; and submitting recommendations to the Chief of BUMED for developing proposals which identify and provide means to rectify the problems of child abuse and neglect.

The broader intent of the program was also apparent in the responsibilities assigned to commanding officers of medical facilities. Each of these officers was required to establish a local Child Advocacy Program Committee. This committee was charged with reviewing suspected cases of child maltreatment and evaluating the quality of services rendered. It was also responsible for making plans for definitive management of individual situations and community problems contributing to child abuse and neglect. According to the instruction, the committee might include representatives from the following specialty areas: Pediatrics, Social Work, Red Cross, Public Affairs, Chaplaincy, Local Dependents'School Nurse, Psychiatry, Security, Nursing, Staff Judge Advocate, Psychology, Navy Relief, Civil Engineer Corps, and appropriate local civilian agencies.

In addition to establishing the Child Advocacy Program at the installation level and establishing a Child Advocacy Program Committee, the commander of the medical facility was responsible for appointing a senior member of his staff to chair the local committee and serve as installation Child Advocacy Representative (CAR). As such, this person served as the point of contact for the command on all child advocacy matters within the command and satellite activities. Officers in charge of other medical facilities were required to appoint a CAR to serve as the point of contact for those commands on all child advocacy matters.

Evaluation of the Child Advocacy Programs

In May 1979, the U.S. General Accounting Office (GAO) issued a report to the Congress entitled: Military Child Advocacy Programs--Victims of Neglect.[4] The purpose of the report was to critique current efforts within the military services to deal with child abuse and neglect.

The report began by justifying military child maltreatment programs on the basis of published estimates of the magnitude of the problem throughout society and the higher prevalence in the military community of stress factors allegedly leading to child maltreatment. Following evaluation of existing military programs, the report presented conclusions and recommendations for improving program effectiveness.

The GAO concluded that the independent development of programs within each branch of the military, without overall guidance from the Department of Defense, had led to inconsistent policies, such as placement of child advocacy programs within the organizational structure of each service, age differences in the services' definition of a child, and organization and management of child advocacy programs at the installation level.

The need for centralized guidance was recommended in coordinating military programs with local civilian social welfare organizations, particularly with respect to the issue of jurisdiction. Further improvements recommended at the installation level included higher program priority and greater resources, additional staffing to augment existing collateral duty efforts, expanded education and training for all members of the military community aimed at identification and prevention of child maltreatment, and procedural training for persons dealing directly with maltreatment cases.

To improve the organization and operation of the programs, the GAO recommended that the Secretary of Defense establish a small centralized group to serve as a focal point for bringing consistency to the services' child advocacy regulations, developing education and training materials for improving child advocacy programs at the installation level, providing guidance to the services regarding how to handle the difficulties posed by exclusive jurisdiction installations when dealing with child maltreatment problems, and communicating with military installations and the National Center on Child Abuse and Neglect regarding child advocacy matters in general. Additionally, the Secretary of Defense was advised to direct the Secretary of the Navy to place responsibility for its child advocacy program at a level high enough to encompass all Navy installations and personnel.

The concluding section of the GAO report was directed to problems surrounding development of military child maltreatment reporting systems. The GAO report alleged that child maltreatment registries currently maintained by the individual military services were incomplete and ineffective, both for developing meaningful statistics on military child maltreatment problems and for maintaining information on prior maltreatment reports that could be used for assessing whether a child is in danger.

Because of the sensitive nature of child maltreatment information, the different report systems maintained by the military services, and the reluctance to report child maltreatment incidents, the GAO recommended that the Secretary of Defense establish a single DoD policy for collecting and using information on suspected and confirmed cases of child maltreatment.

THE DOMESTIC VIOLENCE ISSUE

For many decades there have been sporadic protests from family action groups and the legal community challenging traditional responses to the problems of domestic violence. These protests intensified with the revival of the feminist movement.

As with child abuse, the traditional response to domestic violence had been predominately crisis oriented. Intervention was largely tertiary, with attention primarily directed to the immediate medical needs of the victim and prosecution of the perpetrator. During the 1970s, demands increased for expanded social services and for new civil and criminal protection for abused wives, as well as for children. In the military, conferences were held that included discussions on family advocacy issues;some existing Child Advocacy Programs were expanded to include policy and guidance on spouse abuse. The focus broadened to include not only the treatment of domestic violence cases, but also education and prevention efforts. In addition, a military family resource center was established and specialized training was conducted for human service professionals handling domestic violence cases.

Federal and State Initiatives

Between 1975 and 1980, 44 States passed new legislation addressing domestic violence. Most of the statutes created new civil and criminal remedies for persons abused by household members. Some were directed to the powers and duties of police answering domestic disturbance calls. Others required agencies providing services to violent families to maintain records and case reports. In 29 of these States, the new laws allowed the courts to evict an abuser from a residence shared with the victim. Many state and local governments appropriated special funds for shelters and other services related to family violence.[5]

At the federal level, the Department of Justice, through the Law Enforcement Assistance Administration (LEAA), launched a Family Violence Program in 1977. A basic assumption of this program was the importance of the criminal justice system in reducing family violence. The program supported more than 30 comprehensive demonstration projects involving relevant public and private agencies. These projects provided resources to courts, police departments, and prosecutor's offices to develop and test ways in which the criminal justice system could become more responsive and effective in handling domestic violence cases.

In the fall of 1979, the Department of Health and Human Services established the Office on Domestic Violence. Its purpose was to coordinate research and social services related to domestic violence in what was then the Department of Health, Education, and Welfare. In addition, it was to establish an information clearinghouse and provide technical assistance to organizations developing programs at the local level. However, funding inadequacies hampered the effectiveness of this office. In 1981, the office was closed and its outstanding grants and contracts were transferred to the National Center on Child Abuse and Neglect (NCCAN).[6]

In February 1981, a "Domestic Violence Prevention and Services Act" (H.R. 1651) was initiated in the House of Representatives. The bill was referred to the Subcommittee on Select Education under the House Committee on Education and Labor. The broadening of national concern from the medical and legal aspects of domestic violence to the social aspects of the problem was reflected in this proposed legislation.

Despite the failure of the House to act on this proposed legislation, continued Congressional interest in domestic violence is reflected in a companion bill, containing identical objectives, that was introduced in the Senate on September 8, 1982 (S2908). This bill was referred to the Subcommitee on Aging, Training, and Human Services under the Committee on Labor and Human Resources.

Navywide Family Awareness Conference: 1978

A Navywide Family Awareness Conference was convened in November 1978, jointly sponsored by the Chief of Naval Personnel and the Navy League. The

aim of this conference was to better identify the needs of Navy families for more effective program response. More than 700 individuals, representing active duty personnel, retirees, Naval Reservists, Navy dependents, and civilian observers and resource persons participated in the conference.[7]

Workshops at this conference produced more than 200 recommendations, many of which related to program needs in the area of domestic violence. Recommendations from this conference contributed significantly to the establishment of the Navy Family Support Program in January 1979 and the issuing of BUMED NOTE 6320 (February 29, 1979), which established policy and guidance for handling spouse abuse.

The Air Force Conference on Families: 1980

In July 1980, recognizing the inextricable link between family well-being and mission readiness, the Air Force established the Office for Air Force Family Matters within the Directorate of Personnel Plans. Shortly thereafter, in September 1980, an Air Force Conference on Families was convened at Randolph Air Force Base, Texas.

The dominating theme of this conference was the need for change in addressing the needs of military families. Among the recommendations produced at this conference, several were related directly to improving program responses to child maltreatment and domestic violence.[8]

In September 1981, the Air Force Office of Family Matters sponsored a second conference on families in Washington, D.C. One purpose of this conference was to inform conference attendees of the current status of recommendations made at the 1980 Conference on Families. Included in the conference report was an update on family advocacy programs in the Air Force. According to the report, the Child Advocacy Program was expanded in August 1981 to include the entire family. This new program added a "spouse abuse" component to the previously existing child maltreatment program.[9]

The Army Conference on Families: 1980

In October 1980, the Army Officers' Wives Club of the Greater Washington Area and the Association of the United States Army jointly sponsored a symposium in Washington, D.C. The theme of the symposium was "The Army

Family: Analysis and Appraisal." One of the primary goals of this conference was to provide a platform for the identification and exchange of ideas concerning issues facing the Army family in the eighties.

The concerns, needs, and problems of Army families were reviewed in thirteen conference workshops, one of which addressed specific family problems. Recommendations from this group included several that were related to improving program responses to child maltreatment and domestic violence. It was recommended, for example, that the Army provide command-supported shelters for victims of family violence.[10]

In addition to these recommendations, conference attendees also recommended that the Army establish a family liaison office within the Office of the Chief of Staff, Army. In response to this recommendation, the Army established such an office in the Fall of 1981, under the Office of the Deputy Chief of Staff for Personnel. Also in partial response to the conference, the Army added a family advocacy coordinator to its Community Service Division to further support its worldwide network of Community Service Centers.

Since the 1980 Army Family Conference on Families, the Army has held both 1981 and 1982 follow-up conferences. The themes of these conferences have been directed primarily at advocating support services and programs that reduce family stress and lend strength to Army families.

The Military Family Resource Center: 1980

Based on a GAO recommendation to create a resource center to serve the military worldwide, the National Center on Child Abuse and Neglect established the Military Family Resource Center (MFRC) in October 1980, under the auspices of the Armed Services Department of the YMCA. The MFRC was created to support family advocacy in the military services and to assist professionals who provide help to military personnel and their families. Although the center was initially created as a three-year demonstration project under a grant from NCCAN, the MFRC is being incorporated as a permanent part of the Defense Department's overall family support system.

The Conference on Domestic Violence in the Military Community: 1981

In March 1981, a conference on domestic violence in the military community was held in Savannah, Georgia. The conference was jointly sponsored by the Center for Women Policy Studies, Washington, D.C., and the Family Violence Project of the Coastal Area Community Mental Health Center, Hinesville, Georgia. It was funded by LEAA, U.S. Department of Justice, and attended by military personnel, civilian social service workers, health professionals, clergy, and lawyers. Among the themes heard at the conference was the toll that spouse abuse in the armed forces takes on combat readiness, performance, and retention. Working groups prepared more than 30 recommendations including suggestions that the DoD should both issue a family advocacy directive, and ask Congress to appropriate funds for program implementation.[11]

The Coast Guard Family Advocacy Symposium: 1982

In March 1982, the Coast Guard Wives Club of Washington, D.C. sponsored a family advocacy symposium. This symposium was attended by approximately 60 representatives, including personnel from Coast Guard headquarters and wives of Coast Guard members. In July 1982, the Coast Guard initiated the development of family advocacy policy and program guidelines in its Military and Family Services Branch. Three months later, a second family advocacy symposium was convened in Washington, D.C., with 50 representatives present. This meeting, sponsored jointly by the Coast Guard Office of the Chief of Staff and the Coast Guard Wives Club of Washington, D.C., was called to provide support and assistance to the development of a Coast Guard Family Advocacy Program.

Family Advocacy Training Programs: 1982

For the last three fiscal years (1981, 1982, and 1983), Congress has appropriated funds for use by military Family Advocacy Programs. Of the 5 million appropriated by Congress for fiscal year 1983, the Navy received 2 million, and the Army and the Air Force 1.5 million each. Distributed among the services by the Department of Defense's Tri-Service Family Advocacy Program Office, $500,000 of the Navy's money was later transferred to the Marine Corps.

Each of the services used a portion of this money for training workshops or conferences in the treatment and prevention of child maltreatment and spouse abuse. In spring 1982, the Air Force Surgeons General's office sponsored a series of 13 workshops for military professionals who deal with family violence issues. In September 1982, the Navy sponsored ten workshops with representatives from 60 bases. The workshops focused on training Navy professionals involved with domestic violence to develop a coordinated service response. The Marines also held two three-day family advocacy workshops in August and September 1982. The Army dealt specifically with family advocacy issues in an August 1982 conference for the European Command, while a CONUS conference was held under the auspices of the Health Service command. A worldwide workshop was undertaken by the Army Community Services. Each service has planned further training in skills development and implementation of regulations for 1983.

Evaluation of Spouse Abuse Programs

In 1981, the Center for Women Policy Studies (CWPS) published an extensive study of spouse abuse in the military entitled: Wife Abuse in the Armed Forces.[12] The study was jointly funded by LEAA and the Administration for Children, Youth, and Families in the Department of Health and Human Services. The objectives of the project were: to investigate the problem of wife abuse in the military and identify some of the elements that may be exacerbating the problem; to examine current military policies and programs that deal with spouse abuse; and to recommend steps for developing and improving programs to better serve military families. Information for the study was drawn from more than 90 interviews with DoD policymakers and other military and civilian social services, legal, and medical officers. In addition, CWPS researchers visited military programs providing service to violent families at six military installations in the United States representing each service branch and six Army bases in West Germany.

Study results pointed to the seriousness of spouse abuse in the military and stressed the importance of a coordinated service delivery response by the entire Armed Forces community and chain of command.

Although CWPS researchers complimented the initial efforts of the Armed Services to respond to the needs of violent families, they underscored the need for continued emphasis on policy and program development to ensure a full range of services for battered women and their families.

CURRENT STATUS AND DIRECTIONS

The Department of Defense Directive

Stimulated by a recommendation from the GAO, the DoD established a Family Advocacy Committee in 1979 to develop a single policy statement for all services. On May 19, 1981, DoD issued an all-service policy directive establishing a Family Advocacy Program (FAP). This directive mandated that each service (Army, Navy, Air Force, and Marine Corps) create a program to address the prevention, evaluation, and treatment of child abuse, spouse abuse, and child neglect. The Coast Guard, in the Department of Transportation, was also invited to participate in all DoD family advocacy matters.

Although the initial draft included spouse neglect as well as spouse abuse, spouse neglect was deleted from the final draft. The Office of the Secretary of the Defense believed that spouse neglect had too many social policy implications, was too difficult a subject to address, and was not amenable to the case reporting form.13

As it now stands, the DoD Directive is a policy statement, rather than a working instrument with specific program elements. Although it provides a broad structure for implementing programs within the services, it is a statement of the DoD's recognition of the problem and a commitment to address it. The directive advocates a coordinated, but not necessarily a uniform approach to family advocacy in each of the services. Each of the services implements the directive based on its own requirements and resources.

Response From the Military Services

The Air Force responded to the DoD Directive on November 5, 1981, with a modification of Regulation 160-38, which established their Child Advocacy Program. This regulation was reentitled "Air Force Family Advocacy Program," and the modifications were limited to incorporating "spouse abuse"

and "spouse abuser" into the existing child abuse and neglect program regulation. More recently, the Marine Corps issued order 1752.3, dated March 8, 1983, through its Family Service Program that established policies and guidance for implementing a Marine Corps family advocacy program. The Army and Coast Guard are now preparing policy statements and regulations for their respective service branches in fulfillment of requirements under the DoD Directive. On July 11, 1979, and prior to issuance of the DoD Directive, the Bureau of Medicine and Surgery (BUMED) in the Navy established a Family Advocacy Program. In fact, there are many similarities between the Navy Instruction and the DoD Directive. The Navy now has in preparation an instruction converting its BUMED Family Advocacy Program into a service-wide program conforming to the DoD Directive.

SUMMARY AND CONCLUSION

In the past decade, issues posed by child and spouse abuse have become a national concern. The armed forces have shared in this concern. Response to these problems began with local initiatives directed toward child abuse, and later, spouse abuse. In May 1981, a policy directive was issued at the DoD level. This directive should lead to more cooperation beween the military services in responding to family advocacy issues and greater support of their efforts and needs. In response to the directive, individual services are now working to expand and to coordinate their family advocacy efforts. Program policies are being issued and modified, and training is being directed toward personnel who deal with family advocacy issues.

The eventual outcome of these policy developments are unknown. One thing is certain, however: policy developments alone will not solve the problem of child and spouse maltreatment in the military. A shortage of funds could seriously jeopardize the best of plans.

NOTES

1. See, for example, R.D. McCullah, "Effects of Family Dysfunction on Military Operations: Mental Health Needs," in E. Hunter and T. Shaylor, eds., The Military Family and the Military Organization (Washington, D.C.: the Adjutant General Center, 1978).

2. K. Bain, I.D. Milone, D.S. Wenger, J.P. Fairchild, and H.L. Moore, "Child Abuse and Injury." Military Medicine 130 (August 1965): 747-762;
C.R. Wichlacz, D.H. Randall, J.H. Nelson, and C.H. Kemp," The Characteristics and Management of Child Abuse in the U.S. Army-Europe," Clinical Pediatrics 14 (1975): 545-548.

3. See Public Law 93-247, the Child Abuse Prevention and Treatment Act, Section 2(b), p.6.

4. U.S. General Accounting Office, Report to Congress: Military Child Advocacy Programs--Victims of Neglect (Washington, D.C.: U.S. Government Printing Office, 1979).

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6. J.N. Santos, "Federal Response to Domestic Violence," in Domestic Violence in the Military Community (Washington, D.C.: Center for Women Policy Studies, 1981).

7. Navy Family Program Branch, Final Report of the Navywide Family Awareness Conference (Washington, D.C.: Office of the Chief of Naval Operations, 1978).

8. Office of Family Matters, The Air Force Family Conference (Washington, D.C.: Department of the Air Force, 1980).

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10. E. Van Vranken, R. Buryk, and E. Hamlin, eds., Report on Family Issues (Washington, D.C.: Department of the Army, 1980).

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13. L. Gerson, "Department of Defense Policy on Spouse Abuse Programs and Family Advocacy Program Directive," in Domestic Violence in the Military Community: Conference Report (Washington, D.C.: Center for Women Policy Studies, 1981).